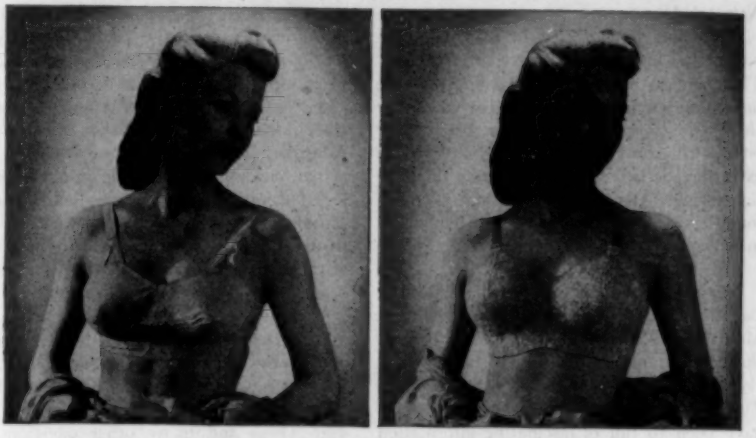
Sagging Breasts
Progressively Lose Tone!



Before - and after - she got her Spencer Breast Support designed especially for her.

HAVE A SPENCER BREAST SUPPORT DESIGNED JUST FOR YOU!

You know that sagging breasts mean weakened tissues and impaired circulation—so why neglect them? Medical research has shown that proper support helps prevent serious breast conditions. Your Spencer Breast Support will be designed especially for you to give proper support, smart lines, perfect comfort. No drag on shoulders—no riding up in back. Aids nature to restore tissue tone.

Write or Phone for FREE information

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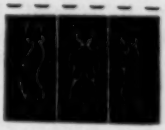


Lordosis Breast Ptosis

Send booklet. I have checked my problem. ☐ ☐ ☐

Name.....

Address.....

City.....Prov.....177-6-50

individually designed SPENCER SUPPORTS

Between Ourselves

This is it! The month toward which so many nurses have been looking forward—the month when we travel to Vancouver for the ***25th convention of the Canadian Nurses' Association.***

The third largest city in Canada, Vancouver has long been a Mecca for travellers. There are so many interesting spots in the immediate environs of the city to visit, that those nurses who have never been there before will want to arrange to stay for an extra day or two so that they may do some sightseeing. **Alison Wyness** has sketched some fascinating word pictures to tempt you to linger longer.

* * *

Last July one of our very well-known Canadian nurses, **Lyle Creelman,** flew from Montreal to Geneva, via London, to become the consultant in Maternal and Child Hygiene in the World Health Organization. The personal letters she has written home have been so full of fascinating information that we have asked her to prepare a regular release for publication in *The Canadian Nurse* each month. The first appears in this issue, under the caption ***"Lyle Creelman Writes."*** We know you will enjoy these glimpses of "faraway places with strange sounding names." Watch for them every month.

* * *

While there are no figures available on the actual incidence of increased blood pressure, it is found very commonly. ***Primary or essential hypertension*** is a separate clinical entity. For some unknown reason vascular tone is increased. Hypertension develops without any determinable pathological changes in the beginning. With the persisting high blood pressure, eventually the clinical picture of damage to the blood vessels and other organs appears. Studies that have been made of essential hypertension seem to indicate that inheritance has some bearing on the problem.

Solving some of the problems of hypertension, while at the same time providing a place for treatment, is the role of the special clinic established at the Winnipeg General Hospital. **Dr. R. E. Beamish** and **Dr. J. D. Adamson** have prepared an excellent digest of the relevant facts for your information.

Supplementary nursing care information is contained in the article by **Margret Sigmundson** and **Clara Einarson.** One aspect of the community problem in hypertension is described by **Suzanne Petursson.**

* * *

How can nurses assist with the ***finding of clues*** when victims of assault, etc., are brought into our hospitals? What should the nurse do with the clothes of an injured person? These and many other questions are answered in the interesting article by **Sub-Inspector Carl LeDoux** which begins in this issue. It is such a fascinating topic that even the stenographer in our office, who typed the copy to go to the printers, was loath to stop until she had finished. A long article, it will be spread over two or three issues.

* * *

The series of articles dealing with ***evaluation and accreditation*** is concluded with **Agnes J. Macleod's** challenge to the voting delegates at the forthcoming convention. The need for this type of service is clear. The expense involved would be more than justified in the years to come. Ponder the matter carefully before you vote.

An interesting sidelight on the advancement of medical and pharmaceutical procedure is illustrated in an old pharmacy order, dated 1794, which was presented to Dean R. O. Hurst of the Ontario College of Pharmacy by Allen and Hanburys Ltd., London, Eng. Among a wide variety of medications and other drugs is a request for 24 lb. of opium.

The past 50 years have witnessed many great advances in medicine, but none more dramatic than the discovery that penicillin is truly a life-saver where cases of subacute bacterial endocarditis are concerned, it is stated by the Canadian Heart Association. Until 1944, it was rare for a person suffering from this heart ailment to recover—now, it is just about as rare for one to die.

Like an Angel of Mercy TO YOUR SKIN

Dainty, Greaseless Skin Cream Helps Hands, Complexions Look Lovelier. Nurses find many other uses for this Famous Beauty Aid

● If you're ever troubled with annoying blemishes, dryness or roughness . . . if your hands are red and rough from having them in hot water or strong solutions too often—try Noxzema Skin Cream as a dainty, greaseless beauty aid.

Thousands of nurses use Noxzema every day as their all-purpose beauty cream—their regular powder base and night cream. You'll be delighted at the way this greaseless, medicated cream helps your skin look softer, smoother, lovelier.

And here are many other uses for Noxzema that nurses have discovered. After a tour of duty when your feet are burning and tired... smooth on cooling *medicated* Noxzema. See if you don't agree it's "like wading in a cool stream." Or next time you shave your legs, apply this greaseless cream first... see if it doesn't take the drudgery out of shaving. And rub a little on your arms and elbows to help soften and smooth them.

There are many more beauty and comfort tips inside every package of this dainty cream. Try them. You'll be sharing the secret of smart women all over Canada who agree that dainty, greaseless Noxzema is truly "An Angel of Mercy" to their skin.

FOR YOUR PATIENTS' COMFORT

Try Noxzema Skin Cream to help heal the sore irritation of patients' sheet burns. They'll appreciate the delightful soothing relief they get from Noxzema's *medicated* formula. And here's a *new idea* in skin comfort they'll love! Use this dainty greaseless cream as a refreshing body massage. It's a wonderful skin tonic—will make them feel good *all over!* Noxzema is greaseless—so there's no worry about staining bed linen. Start using Noxzema *today*.

New Products

Edited by **PROFESSOR F. N. HUGHES**

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal*

ALUDRINE HYDROCHLORIDE

Manufacturer—Eli Lilly and Company (Canada) Limited, Toronto.

Description—5 mg. and 10 mg. tablets of Aludrine (1-(3, 4-dihydroxyphenyl)-1-hydroxy-2-isopropyl-aminoethane) Hydrochloride; also called isopropylepinephrine.

Indications—Treatment of attacks of bronchial asthma and in control of status asthmaticus. Has shown results in cases which do not respond to epinephrine or theophylline.

Administration—Sublingually is often method of choice, usually in doses of 10 mg. for adults repeated as prescribed.

GRAMOLETS

Manufacturer—Schering Corporation Limited, Montreal

Description—Each troche contains 0.25 mg. Gramicidin (antibiotic) and 5 mg. Benzocaine in a palatable slowly-dissolving base.

Indications—For relief of throat irritations and infections due to gram-positive bacteria.

Administration—One every three hours or as prescribed, each sucked slowly until dissolved; not more than 8 should be taken during a 24-hour period.

GRAMINASIN

Manufacturer—Schering Corporation Limited, Montreal.

Description—An aqueous nasal solution containing 0.005% Gramicidin and 0.125% dl-desoxyephedrine hydrochloride.

Indications—For relief of nasal congestion and possible prevention of secondary invaders of the common cold.

Administration—2 or 3 drops into each nostril every 2 or 3 hours or as prescribed. Atomizer may be used. Not more than 6 daily applications of the dosage suggested should be used.

GRAMODERM

Manufacturer—Schering Corporation Limited, Montreal.

Description—Contains 0.25 mg. in each gm. of special ointment base (Procutan).

Indications—For prophylaxis and treatment of superficial skin infections due to gram-positive organisms, as in cuts, abrasions, infected eczematoid dermatitis, impetigo eczematodes, impetigo contagiosa, etc.

Administration—Topically, directly to affected part or on a dressing.

MACRON TABLETS

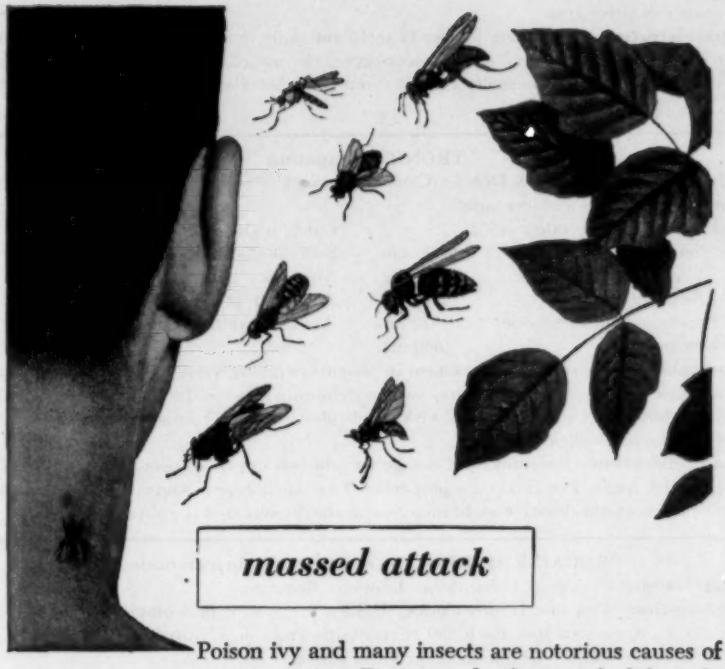
Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Each sugar-coated capsule-shaped, brown tablet represents:

Ferrous sulphate U.S.P.....	0.35 gm.	Pantothenic acid.....	2.0 mg.
Thiamine hydrochloride.....	2.0 mg.	Ascorbic acid.....	50.0 mg.
Riboflavin.....	2.0 mg.	Liver concentrate (boiling-water extract).....	0.5 gm.
Nicotinamide.....	10.0 mg.		
Pyridoxine hydrochloride....	1.0 mg.		

Indications—For prophylaxis and treatment of secondary and nutritional anemias; not for pernicious anemia.

Administration—Prophylactically, as in pregnancy, one or two tablets daily. Therapeutically, usually three tablets daily.



massed attack

Poison ivy and many insects are notorious causes of severe pruritus. Prompt and safe control of the itching is a prime therapeutic need, for the patient's scratching or self-medication can lead to serious sequelae.

Calmitol Ointment gives relief directly upon application. It may be used liberally and repeatedly without the risk of exacerbation, for Calmitol Ointment is free from dangerous drugs such as phenol (as in calamine with phenol), cocaine and cocaine derivatives.

Active ingredients:
Camphorated chloral
Hyoscyamine oleate
Menthol

The Leeming Miles Co. Ltd. *1 Notre Dame St., W., Montreal, Canada*

P.A.S. TABLETS

Manufacturer—Ayerst, McKenna & Harrison Limited, Montreal.

Description—Each tablet contains 0.5 gm. of paraaminosalicylic acid.

Indications—For adjunctive therapy in tuberculosis, particularly in toxic, febrile patients with acute exudative type.

Administration—Suggested dosage, 12 to 16 gm. daily in divided doses on a full stomach as far as possible. If digestive disturbances occur, the use of sodium bicarbonate or phenobarbitone and atropine will usually control symptoms. Acetylsalicylic acid is contraindicated in P. A. S. therapy.

TRONIC Compound

Manufacturer—Sharp & Dohme (Canada) Limited, Toronto.

Description—Each cc. contains:

Protein hydrolysate (45% amino acids)	0.15 gm.	Calcium glycerophosphate	2.80 mg.
Thiamine hydrochloride	.088 mg.	Sodium glycerophosphate	5.60 mg.
Riboflavin	.044 mg.	Manganese glycerophosphate	0.35 mg.
Pyridoxine hydrochloride	.022 mg.	Potassium glycerophosphate	0.53 mg.
Niacinamide	.660 mg.	Alcohol with flavoring agents added	17%

Indications—As a dietary supplement in patients requiring Vitamin B-Compound therapy in conditions such as loss of appetite, various debilitated states, during pregnancy, and for growing children, and also in patients with febrile illness and after surgery in which there may be a delayed convalescence.

Administration—Recommended dosage for adults is one tablespoonful three times daily before or with meals. For children a proportional similar dosage is suggested. In the presence of frank deficiency the dosage may be increased at the discretion of the physician.

PROCAINE HYDROCHLORIDE 0.2%, intravenous

Manufacturer—Abbott Laboratories Limited, Montreal.

Description—Procaine Hydrochloride, U.S.P., 0.2% w/v, in Isotonic Sodium Chloride Solution for intravenous use. Each 500 cc. contains Procaine Hydrochloride, U.S.P., 1 gm., Sodium Chloride, U.S.P., 4.5 gm. in water for injection.

Indications—For intravenous infusion in painful conditions associated with extensive burns, arthritis, etc.

DERM CREAM

Manufacturer—Ingram & Bell Limited, Toronto.

Description—A soothing cream with water miscible base containing in each ounce:

Crude coal tar	2½%	Calamine B. C. P.	2½%
Titanium dioxide	7½%	Cetyl trimethyl ammonium bromide	1%
Zinc oxide	7½%	Benzocaine	5%

Indications—For the treatment of atopic eczema and allied skin conditions. The use of a water miscible base permits easy removal and the incorporation of a local anesthetic gives prompt relief of irritation and alleviates the tendency to scratching.

Ontario

The following are recent staff changes in the Ontario Public Health Nursing Service:

Appointments: *Isabel Black, B.S.*, has returned from Teachers College, Columbia University, to resume her work as regional supervisor with the Division of Public Health Nursing, Ontario Department of Health, with headquarters at North Bay; *Elizabeth Macpherson* (Royal Infirmary, Scotland, and University of Edinburgh public health course) to Espanola; *Eleanor Reynolds* (Wellesley Hosp., Toronto, and University of Toronto general course) to Sault Ste. Marie Board of Education.

Resignation: *Edna Thomas* from Fort Frances to return to England.

BEREX—Succinate-Salicylate Therapy

in ARTHRITIS RHEUMATISM

EXPERIENCE HAS PROVED that salicylates are the agent of choice in the treatment of Arthritic and Rheumatic disorders. But toxic and other unpleasant reactions often result when large and sustained dosage of salicylates is necessary in chronic and acute cases of Arthritic and Rheumatic disturbances.

This difficulty has been overcome. Clinically it has been demonstrated that the depressant effect of salicylate on blood prothrombin is averted when acetylsalicylic acid is administered in combination with calcium succinate as it is in BEREX.

BEREX combines these proven advantages:

- BEREX gives prompt relief of painful symptoms.
- BEREX obviates salicylate toxicity and may be prescribed without fear of untoward side-effects such as hypoprothrombinemia or hemorrhagic tendency and is, therefore, suitable for protracted therapy.
- BEREX is easily administered . . . reasonable in cost.

BEREX contains, per tablet: calcium-succinate 2.8 grams, acetylsalicylic acid, 3.7 grains.

BEREX may be obtained through your prescription pharmacy—in bottles of 100 tablets or in bottles of 500 tablets designed for dispensing and institutional use.

Complete clinical information concerning BEREX in the treatment of Arthritic and Rheumatic disorders will be sent on request to

BEREX Pharmacal Co., 36-48 Caledonia Rd., Toronto, Canada

Patented 1949. Manufactured under License from the Proprietors.
BEREX is the trademark of this product.

a step forward

IN SIMPLE ANALGESIA

For 50 years acetylsalicylic acid in tablet form has proved of inestimable value to mankind. However these tablets are comparatively insoluble, and clinical investigation has demonstrated the irritant effect of the undissolved particles of acetylsalicylic acid on the gastric mucosa. For these reasons the calcium salt of acetylsalicylic acid — calcium acetylsalicylate — is to be preferred.

A step forward has been taken with 'DISPRIN', containing 5 grains acetylsalicylic acid and producing, in water, 6 grains of calcium acetylsalicylate. Thus, 'DISPRIN' offers all the well-known advantages of acetylsalicylic acid without its disadvantages.

'DISPRIN' is soluble and palatable. It can be administered with ease, especially to children. 'DISPRIN' is more speedily assimilated and less rapidly eliminated, thus accelerating the analgesic effect. 'DISPRIN' is substantially neutral and is less likely than ordinary acetylsalicylic acid to cause irritation of the gastric mucosa.

A trial supply and literature will be gladly sent on request.

SOLUBLE
NEUTRAL
PALATABLE
STABLE

RECKITT & COLMAN (CANADA) LIMITED
Pharmaceutical Division, Montreal

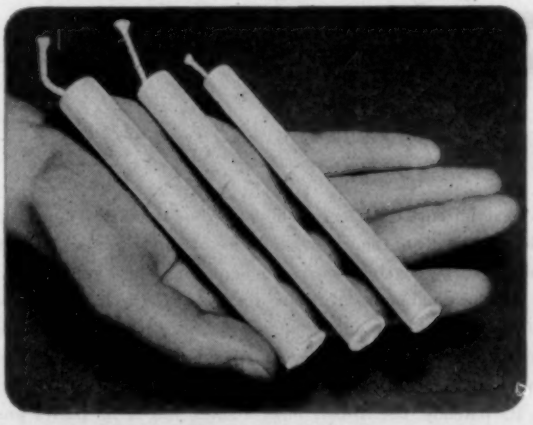
'DISPRIN' — ***by the makers of*** **'Dettol'** ***Antiseptic***

TAMPAX FACTS NO 3

Properly used, they provide "complete absorption of the flow."[4]

Correct tampon size in relation to vaginal length and caliber (with proper technique of insertion) are the only prerequisites of complete protection during the menstrual period. Tests, under conditions of use with the expansion of the tampon restricted, indicate the average absorbency for Super TAMPAX as approximately 17 cc, for Regular TAMPAX approximately 12 cc and for Junior TAMPAX approximately 9 cc—whereas, actual clinical studies[1] of a representative group of women show the periodic flow to average only 50.55 cc. Thus, with correct usage and absorptive capacity of more than 170 cc, 120 cc and 90 cc in each package of ten Super—Regular—Junior TAMPAX tampons respectively, the margin of safety assures adequate protection for the entire period—simply by inserting the tampons at proper intervals. Besides providing ample absorptive capacity, TAMPAX is safe,[3] comfortable,[4] and convenient.[5] Its use has also been reported as psychologically beneficial.[2]

The fact that, during the last 14 years, *over 2 billion* TAMPAX have been purchased reflects the strong confidence that women place in their physicians' judgment.



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Available, at no cost, are professional samples of the three absorbencies of Tampax—Regular, Super and Junior. Just fill out and mail the coupon below.

TAMPAX

The Internal Menstrual Guard of Choice

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CANADIAN TAMPAX CORPORATION LTD.
Brampton, Ontario.

Please send professional supply of TAMPAX in the three absorbencies and related literature.

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THE VITAMIN HOUR

.... *can* be like this!

When the Vi-Daylin bottle is opened, children come running. They smell this honey-like liquid, taste the lemon-candy flavor, and are quick to take the prescribed dose—no coaxing, no coyness here. One teaspoonful a day is the average dose for children up to twelve years old. Vi-Daylin is ideal for babies too, as it's easy to mix with formula, fruit juice or cereal. Contains practically no alcohol—less than 0.5%. For mothers there's an extra bonus —Vi-Daylin has no fishy odor, stays fresh without refrigeration. The formula shows its potency, the Abbott label assures you of its purity and stability. Vi-Daylin is obtainable in two convenient sizes: 90-cc. and 8-fluid-ounce. ABBOTT LABORATORIES, LIMITED, MONTREAL.

Abbott

Each 5-cc. teaspoonful of Vi-Daylin contains:

Vitamin A	5000 Int. units
Vitamin D	1000 Int. units
Thiamine Hydrochloride	1.5 mg.
Riboflavin	1.2 mg.
Ascorbic Acid	40 mg.
Nicotinamide	10 mg.

SPECIFY *Vi-Daylin*
TRADE MARK

(HOMOGENIZED MIXTURE OF VITAMINS A, D, B_1, B_2, C AND NICOTINAMIDE, ABBOTT)

The
CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SIX *NUMBER SIX*

MONTREAL, JUNE, 1950

A Spring or a Pond

Average reading time — 3 min. 12 sec.

ONE OF THE interesting and provocative parts of assembling each month's issue is the preparation of the material that comes under the caption, "In the Good Old Days." It calls for more than just a hurried scanning of this 40-year-old material. It provides a very valuable insight into the professional preoccupations of the nurse leaders of that day. Many of them have gone to their reward and remain only as names to most of us. The sprinkling who are still among us have long since ceased taking an active part in nursing affairs though, interestingly enough, many of them are still subscribers to the *Journal* and follow the present-day developments in nursing education and nursing service with unquenchable enthusiasm.

One of the most interesting monthly issues so far reviewed was the July, 1910, number. The entire issue was devoted to the papers given and a verbatim report of the discussion that took place at the fourth annual meeting of the Canadian Society of Superintendents of Training Schools for Nurses. It is altogether probable that no one else has read this particular issue through with care for at least 39 years. A few brief excerpts from it will be published next month. If space would permit, it might prove very stimulating to reproduce several of the papers for so many of their points are still plaguing us professionally. The most hopeful sign is that nowadays, instead of these matters being mulled over by a small handful of superintendents of nurses, they are being tackled by hundreds of interested nurses all over Canada. Many of the related topics will be discussed during the forthcoming convention in Vancouver.

What are some of these problems that perplexed the nurses of 40 years ago? In her paper on "What the Nurse Owes the Hospital—the Profession—the Registry," Miss Barwick deplored the attitude of young graduates "who seem to think it is their privilege to begin where their older sisters are leaving off." These young upstarts of 40 years ago coolly decided for themselves what types of cases they would and would not nurse! They scorned night duty—there was no such thing as a 3-11 shift in that day or they would doubtless have

been recorded as spurning it too. We still hear the same note of criticism. Nurses have not changed much in 40 years.

Another source of worry was reflected in the paper by Miss Mary Ard MacKenzie, superintendent of the Victorian Order of Nurses, when she said:

> Every graduate nurse should have impressed on her, before graduation, the meaning and importance of an engagement, an agreement or a contract, so that none of them will, as so many do now, regard a contract as something that may be set aside when anything more tempting offers itself.

That still has a familiar ring, hasn't it?

A third speaker was very much concerned over the lack of interest taken by nurses in their own professional associations. Another startled the assembly of superintendents by suggesting the forerunner of our present student nurse recruitment campaigns—that every training school should send a representative to talk to girls in high schools and colleges regarding nursing.

Thus we see that so many of the problems that concern us today are not new. They are still awaiting solution. Are we any closer to finding answers or will our colleagues in another 40 years look back to the reports and discussions of this year's convention and say, "They did not travel very far in solving the problems of nursing."

Several momentous decisions await the voting delegates who will attend this 25th convention of the Canadian Nurses' Association. Through the medium of the *Journal*, these matters have been placed before thousands upon thousands of our members. Our greater strength to meet and solve our problems lies in the multitude of small, local nursing organizations that can, if they will, help to provide the answers.

Perhaps our greatest need today is that each of us should resemble a spring, not a pond. Flowing from the depths, a spring is clear, sparkling, life-giving. A pond is stagnant, dull, and lifeless. A spring gushes out to spread over a wide area. A pond lies inert, a home for croaking frogs. If, like a spring, ideas flow from the depths of our thinking at this year's convention, the vitalizing effect will be felt in nursing all over Canada. If the participants are as indifferent as a pond, progress will be curbed. Are you a spring or a pond?

Victorian Order of Nurses

The following are recent staff changes in the Victorian Order of Nurses for Canada:

Appointments—Calgary: *Lois Maxwell* (Edmonton Gen. Hosp.). Halifax: *Joan Townsend* (Victoria Gen. Hosp., Halifax). Kingston: *Joyce Brightwell* (St. Mary's Hosp., Timmins). Saint John, N.B.: *Charlotte Myles* (Royal Victoria Hosp., Montreal). Toronto: *Elizabeth LePan* (Toronto Gen. Hosp.). Vancouver: *Grace Lackey* (Royal Victoria Hosp., Montreal). York Township, Ont.: *Vera Jolley* (Royal Infirmary, Sheffield, Eng.).

Re-appointment—Moose Jaw: *Catherine Ross* as nurse in charge.

Transfer—*Elizabeth Ferguson* from Arnprior, Ont., as nurse in charge to Kirkland Lake, Ont., as nurse in charge.

Resignations—Calgary: *Eileen Williams*. Chatham, Ont.: *Elsie Jackson*. Kirkland Lake: *Marguerite McNamara* as nurse in charge. Toronto: *Lois Gorman, Barbara Hincks, Margaret Kerr*. Truro, N.S.: *Mona Roberts* as nurse in charge. Welland, Ont.: *Olive Orton*. York Township: *Marion Fricke, Alice Veenis*.

Many people whose younger years were busy, happy and productive feel lost, unhappy and unwanted in their declining years. Guard against this feeling of frustration by preparing yourself for the twilight years. At least ten years before you think of retiring start planning your hobbies for your leisure days.

Vancouver by the Sea

ALISON WYNESS, B.A.Sc.

Average reading time — 24 min. 6 sec.

Land of today and tomorrow—fresh as the morning dew.[1]

KLA — HOW — YAH TILLICUM![5]

VANCOUVER is a city of promise, of opportunity, and of truly great challenge! Largely due to her unique geographical heritage, she not only has rare beauty herself but can also open many doors for you. These will lead you into lands of great splendor and unparalleled loveliness. Some of these trips are near—others, as far distant as the blue Pacific itself. When you are here you cannot help but catch something of the newness of it all—the ruggedness and the space that surrounds Vancouver.

When you pass in and out of her harbor, you will follow the same route as that once navigated by Captain Vancouver in June, 1792. He and his companions were the first white men to enter the inner harbor of the city that bears his name. The previous year, Spaniards had sailed into the outer harbor. Today, the shore-line, where the historic meeting took place between Captain Vancouver and the Spaniards, is known as "Spanish Banks." The historic occasion is recorded on a landmark located on Marine Drive near the University.

You have heard of Stanley Park. Even though it is situated very close to the business centre of town—Paradise could hardly be more beautiful or more varied in appeal. There is something there for everyone. Untamed woods, beautiful man-made rose gardens, recreation of many types — boating, swimming, tennis, golf, riding, cricket, and the ageless joy of hiking through woodland trails that cut deep into forests centuries old. It is surrounded by the sparkling waters of English Bay and Burrard Inlet. On these waters the ships pass —perhaps a great liner from the Orient or just a little pleasure boat or maybe a fishing-smack laden with its morning catch.

Often, you can see little children at play on the sands of the famous beaches or old folk enjoying the companionship of a cosy chat by the sea. You will want to spend some time listening to the birds and other wild life that abounds in the more secluded areas of this 1,000-acre park. A spot you might choose would be along the trail that leads to the "Seven Sisters." Historically, these stalwart Douglas firs were named for seven little girls who lived in Vancouver when it was very, very young. However, the Indians have a unique legend which partly explains why the trees never fail to give a sense of peace and security. This legend, retold by Pauline Johnson, one of Canada's outstanding poets and writers, is called "The Lure in Stanley Park."

The lure originally was an evil soul. The Indians dreaded this witch-like character more than anything else. The great God of the Indians, known as the Sagalie Tyee, was filled with sorrow that

City Archives, Vancouver

The Seven Sisters in the background.

his children should be so afflicted by this evil spirit. As a result, he commanded "His Four Men" (always representing the Deity) that they should turn this evil spirit into stone, so that the curse might be lifted. This the four men did. However, fearing that the evil spirit might still try to work destruction, they decided that at the end of the trail they must place something so good and great that it would be stronger and more powerful than this evil. Only in this way could it truly be overcome. "So they chose from their nation, seven of the kindest men—men whose hearts were filled with love of their fellow-man—and transformed these merciful souls into the stately group of "Cathedral Trees."[4]

Vancouver coast Indians will tell you that this legend reveals their love for kindness and their hatred of cruelty. It also reveals their great love of trees.

> Their saps and gums, their fibres, their leaves, their blossoms enrich, nourish, and sustain the human form; no evil is produced by trees—all, all is goodness, is hearty, is helpfulness and growth. This service to mankind is priceless.[4]

Perhaps you, too, will catch this atmosphere of holiness when you take the trail leading to the "Seven Sisters"!

One of the most interesting features of the Park from the white man's point of view is the "9 o'clock gun." This is an old muzzle-loader made in 1816 in the reign of George III. It bears the coronet and initial "M" of the Earl of Musgrave, Master General of Ordnance at that time. The gun was brought to Vancouver about 1894 and was originally fired only at nine p.m. on Saturdays and Sundays to warn fishermen of the Sunday closing during the fishing season. As the fishermen began to go further afield, the gun lost its effectiveness. This custom was a great convenience for the early settlers as it gave them the correct time each evening. Even though the years have given us the telephone and radio to check our clocks by, the gun still is fired at nine o'clock each evening. The only exception occurred during the war, when it was thought that the flash of the explosion might give information to the enemy. Happily, that period has passed and the people of Vancouver—at home, in church, or wherever they may be—automatically check their watches at 9:00 p.m.

This gun is located at Brockton Point, on the main Park Driveway which follows the sea. A little further on, you will notice the Totem Pole village on a hill above the pool for children's swimming classes. Still further on is Prospect Point and below it is "Siwash Rock," a real landmark with a fascinating Indian Legend. Originally this landmark was known as "Nine Pin Rock."

From both Brockton and Prospect Point the traveller gains a wonderful impression of the mountains of the coast range that guard Vancouver. Unless shrouded in rain and mist, they are a truly majestic sight to behold. Most of their peaks are snow-capped throughout the seasons and at sunset are specially magnificent—so mystic — so immoveable and strangely beautiful.

The most famous peaks are "The Lions." They are commonly known by their British name, being called after the Landseer Lions in Trafalgar Square. However, those of you who love legend and Indian lore be sure to read their story by Pauline Johnson and find out why the Indians call them "Chee-Chee-Yoh-ee," meaning Twins or the two sisters, Peace and Brotherhood.

At the feet of these mountains are found the residential areas of North and West Vancouver. At night their many lights twinkle like candles on the dark hillside. The newest and shortest approach to West Vancouver is over the Lion's Gate Bridge. The construction of this particular bridge is well worth consideration. The more you study it, the more impressed you will be with the engineering skills involved. It was officially opened in November, 1938. The King and Queen drove over it the following year.

When you leave the Lion's Gate Bridge you reach the Capilano River.

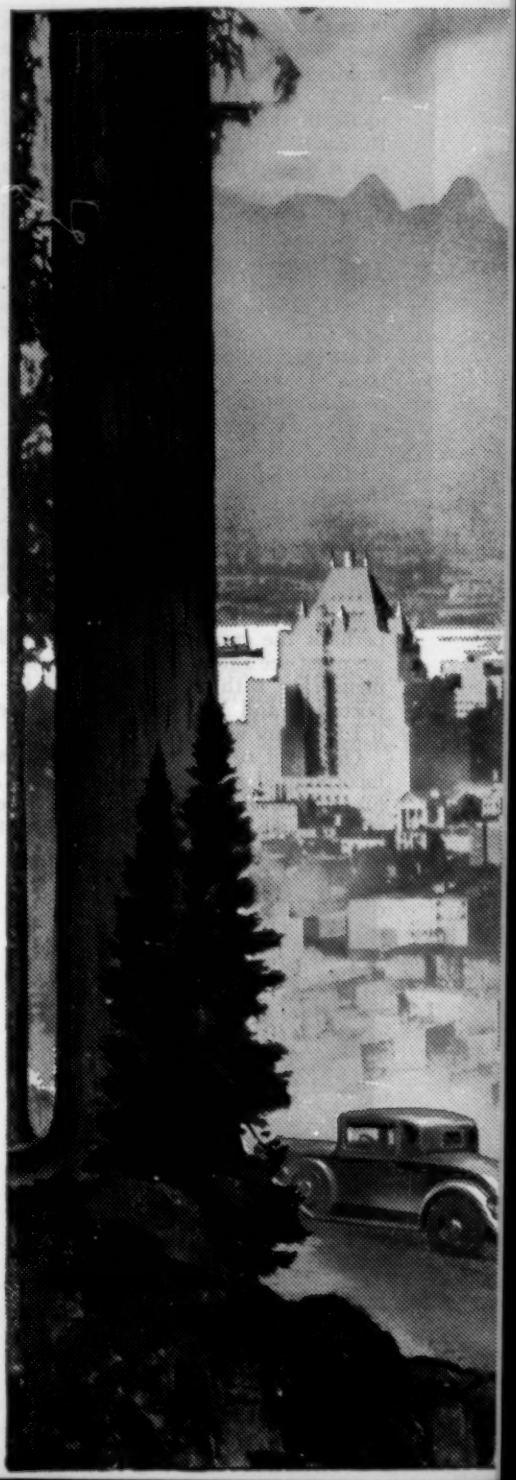
Its course, the dividing line between North and West Vancouver, is one of beauty and grandeur. The river forms a series of canyons over which transportation has been provided for foot travel by means of suspension bridge and cable. There is an attractive tea-room with picnic gardens at the first canyon. In its small entrance park some Indian Totem poles have been collected and add to the picturesqueness of the scene.

The bridge at this particular spot is 450 feet high! It does seem to sway on its steel cables, as you make your way to the opposite bank of the river. Your efforts will be well rewarded for, at the end of the bridge, by the river below, you can find many delightful woodland spots—suitable for a noon-day picnic or evening supper. The further you journey up the Canyon, the wilder becomes the river with the scenery more and more rugged. Here you will find an example of the untamed virility of British Columbia!

If you would like an excellent panoramic view of Vancouver itself, there are two vantage points—one in West Vancouver, the other in North Vancouver. Both are easily reached by motor car. The former is found at the "Lookout" on the British Pacific Properties. This is a new and very special residential area located 1,500 feet above sea level. Her Majesty the Queen, on visiting this spot in May, 1939, is said to have remarked, "I think this is the place to live!" The other vantage point is to be found 3,800 feet above sea-level at the Chalet atop Grouse Mountain. Here you can dine and dance, watching the lights of Vancouver come on, each shedding its own glitter across the inlet waters below.

Nearby are Lynn and Seymour Canyons, each carved by their respective rivers. They are delightful to explore and to picnic. Each has rugged charm, rushing waters. Each has its own possession of pebbles, gleaming white and silver—sometimes wet with rain, often bathed in sunshine.

In the realms of commerce and industry, Vancouver's progress has



been extraordinary, especially in the past decade. In 1870, following the building of the two sawmills, Hastings and Moodyville, a small clearing was made in the forest on the shores of Burrard Inlet. This clearing was called Granville. (Today the main business thoroughfare has retained the name.) This small settlement boasted a two-cell jail, a "customs house," a saloon whose popular proprietor was a very colorful gentleman. His racy tales and stories earned for him the title "Gassy Jack." As a result the clearing was later known as "Gastown." You will find this early name recorded on the admiralty charts and other documents of that day. However, in 1884, Van Horne, of the Canadian Pacific Railway, felt a name should be chosen that was worthy of its possible destiny. He, in turn, is supposed to have mentioned to young Hamilton (the surveyor who laid out what is now Hastings St.), "Hamilton, this is destined to be a great city, perhaps the greatest in Canada, and we must see that it has a name commensurate with its dignity and importance, and Vancouver it shall be if I have my way."[6]

On April 6, 1886, Vancouver was incorporated as a city. Unfortunately, fire completely wiped it out in June of the same year, the population at this time being about 2,000. This is a startling contrast to the present metropolitan population of 505,000. However, it did not take those courageous pioneers long to reestablish themselves. Rebuilding was begun immediately and on September 1, 1886, the first bank, known as the Bank of British Columbia, was opened. Although the first school with its 11 pupils was opened in 1873, it was replaced by a larger unit after the fire, for by that time it had grown to care for 90 pupils. Commercial use of the harbor was made during this year. It may be of interest to note that Vancouver Harbor has 98.2 miles of water frontage, with 48.78 square miles of deep-sea anchorage.

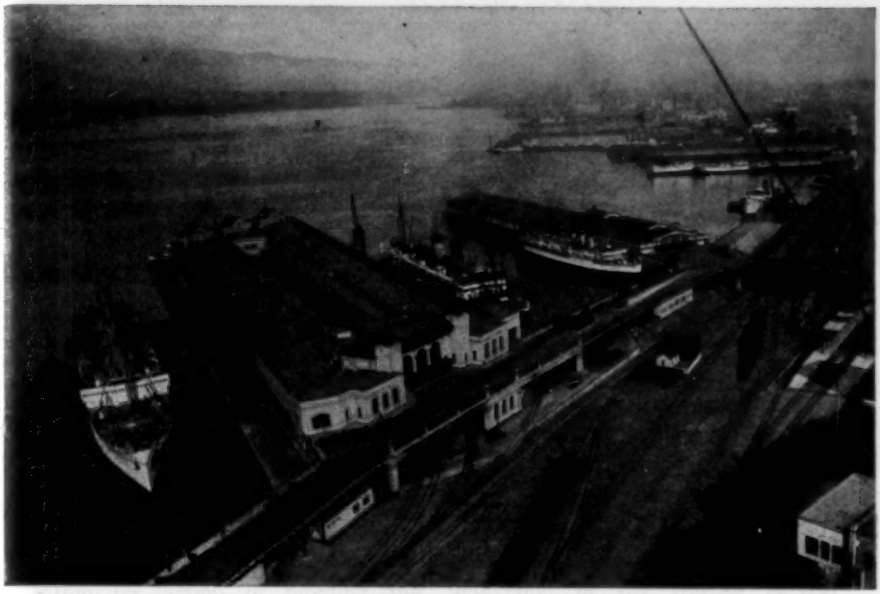
Top of the City Hall

Industrially, Vancouver is still expanding: lumber manufacturing, fish processing, and deep-sea shipping being its prime industries. As the population increases one can expect further development in the field of manufacture.

If you travel to Vancouver by railway this summer, remember that it is just 63 years ago since the first transcontinental train reached our city. That was a great day in the history of the Canadian Pacific Railway, of Canada, and of Vancouver. By the vision of great souls and engineering skill, the isolation of the early pioneers was overcome. Coast to coast was now linked by bands of steel. Thus, a truly great contribution had been made to the cause of Canadian unity and progress.

Since those years, much has been accomplished to further our communication with the rest of Canada. Although the Rocky Mountains form a definite natural barrier, they are now traversed by air as well as train. The city's international airport has the record of being the safest on the North American continent. It is located near the mouth of the Fraser River, eight miles from the centre of the city.

As a city develops and grows older, many fine buildings are gradually erected. Among the more recent is the City Hall built at a cost of one million dollars. It was financed by "baby



You sail from here going to Victoria.

bonds" and is now completely paid for. Then there is the new Hotel Vancouver. It is jointly owned by the two trans-Canada railway companies. Those experienced to judge have said it is one of the Dominion's best. Finally, you will notice the Marine Building. It is the tallest commercial building and has a green copper roof with penthouse. From the sea, coming into the harbor, it is an outstanding landmark and adds greatly to the character of the city's skyline. It is also the centre of business activity and home of the Vancouver Board of Trade.

There are churches of every creed and denomination. Among them are the Jewish Synagogue, the Catholic Cathedral, the Sikh Temple, the Greek Orthodox Church, and the Citadel of the Salvation Army. Some are of exceptional beauty and fine architecture. One of these, a United Church, is Canadian Memorial, built in memory of Canada's valiant dead who made the supreme sacrifice in World War I. Perhaps the most picturesque is the small Anglican Church of "St. Francis in the Woods" at Caulfeild in West Vancouver. Each is making a worthwhile contribution to the spiritual life of this cosmopolitan seaport town where individual souls are still considered of priceless worth, and the family, the basic unit, in our endeavor to develop good citizens.

As Vancouver is a seaport, one can expect much activity about her harbor. At any time of the day or night, there is life and color on her extensive waterfront. This is largely due to the fact that 50 deep-sea steamship lines maker her a regular port of call. Imports from 35 countries and exports to 52 countries are part of her busy life. The cosmopolitan atmosphere which results can be seen in different ways. Perhaps of special interest to the traveller are the many fascinating stores and restaurants that can be found in the Chinese section. The Italian quarter is developing rapidly and is interested in catering to restaurant trade, serving special dishes reminiscent of Sunny Italy.

There is much material in Vancouver that can be used to develop an appreciation of the different cul-

Aerial view of University of British Columbia with Howe Sound in background.

tures. One concrete example of this is the excellent Folk Festival that is usually an annual event. Each different national group is assisting to build a cultural awareness in the fine art of living. As a result both the Art Gallery and symphony society are gaining much needed public support and talent. Nurses seem to spend much of their leisure time enjoying the cultural assets of this still comparatively young city. Naturally, transportation costs limit the number and variety of outside attractions that we can offer. Perhaps the summer concerts given in the Park are the most unique. There, under the stars on summer evenings, many light operas and similar musical shows are enjoyed by large, enthusiastic audiences.

The University of British Columbia, one of the finest of such institutions in Canada, is situated in Vancouver. As one studies the story of its early beginnings and realizes the many hardships that had to be overcome, one is impressed with the present development. This achievement has been made possible by the active concern of each successive student body in the present and future welfare of their Alma Mater. In fact, it is the very fibre of the University's progress. Their motto *Tuum Est* generally translated to mean, "It is up to you!", has been carried out faithfully by each new group of students so that today it is established as a tradition. Dr. MacKenzie, the present president, told a large group of high school students recently that the University of British Columbia is fast becoming one of the world's great universities.

Let us review some of its stimulating past. In 1877, John Jessop, provincial superintendent of education, first suggested a university for British Columbia. Not until 1890 was Dr. I. W. Powell of Victoria appointed chancellor and a senate elected. The next step, eight years later, was the establishment of Vancouver College. This was affiliated with McGill University, to offer the first year in arts. In 1906, McGill University College of British Columbia was established. The following year, an act was passed endowing the university with 2,000,000 acres of Crown Lands and in 1908 the old Act of 1890 was repealed. The New Act with amendments determines the present constitution of the university.

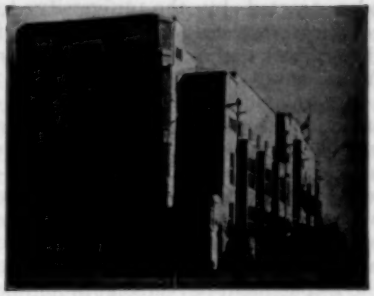
The committee chose Point Grey as the best location. This site was granted in 1911. This grant was later increased to 548 acres. In 1912 the tenders for four buildings were called. Construction was begun early in 1914. Then came World War I and all further development stopped. The bare girders were the bitter symbol of disappointment. True to the tradition of the west, in spite of these facts, the University of British Columbia opened its doors in 1915. Location was then in buildings of the Vancouver General Hospital, some wooden buildings being known as the "Fairview Shacks." The first enrolment was 379 students; today it is about 8,000. With the gradual levelling off of veteran students, an average enrolment of 4,500 is expected.

By 1919, these quarters were most inadequate and truly overcrowded. Early in 1922, students began agitating for action in building the university on the Point Grey site. They formed a most productive Publicity Campaign Committee.

This group did a magnificent job of organization and succeeded in convincing the provincial legislature of the need to continue the building of the University of British Columbia in Point Grey. One example of their untiring zeal is this fact: When the signatures on their petition were counted, there were found to be over 56,000. It is said that it required six page boys to present the rolls to the House! The petition now rests in our Provincial Archives.

Today, 28 years later, their efforts are not only gratefully remembered by the university, but also serve as a challenge to each succeeding group of students to carry on in developing this the second largest Canadian university.

The publicity campaign also included a trek, or parade to the Point Grey site. In protest against government inertia, each student, when he arrived at the new site, picked up a stone and hurled it into a spot near the uncompleted science building. Later, on this site, the stones were made into a Cairn. It is of interest to note that the names of over 1,000 students, who took part in the parade, are inscribed on a paper preserved within the Cairn.



UBC Science Building

It was not until the fall of 1925 that the buildings were ready for occupancy. From this time the history of the university has moved very rapidly indeed. Even during the depression of the thirties several buildings were added. Student endeavor was largely responsible for these important additions. Among these were the student union building, "Brock Hall," in memory of the late Dean and Mrs. Brock; the old gymnasium, the playing fields and stadium. A rough stone monument, itself dating back to the glacial age, has

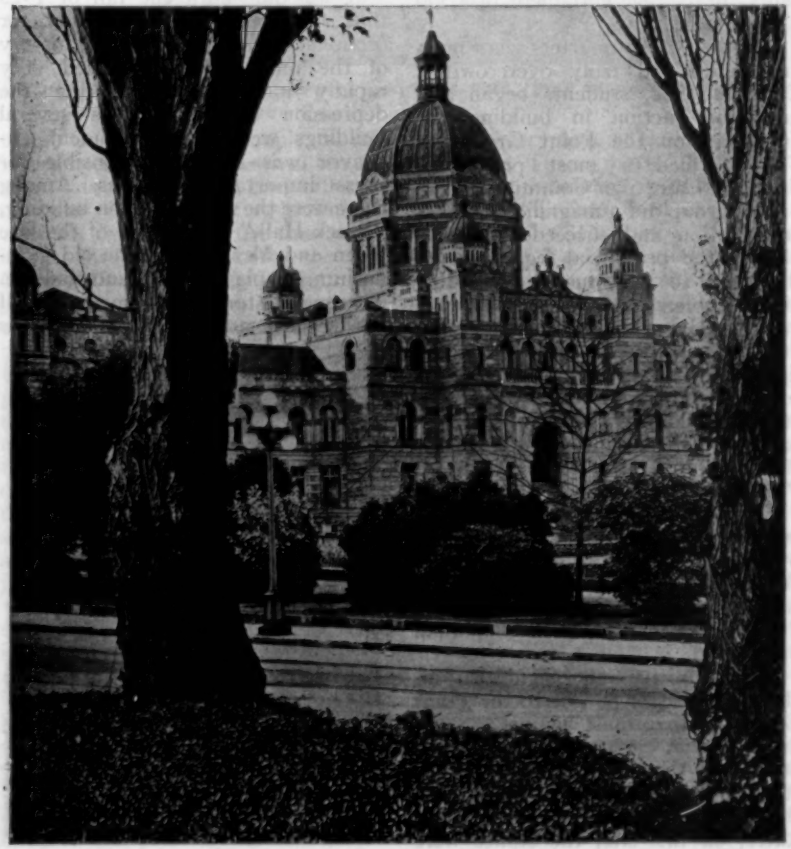
The Cairn

been erected by the university to commemorate the generous actions of the student bodies in providing their Alma Mater with these buildings.

Several buildings are under construction at the present time. These include the new War Memorial Gymnasium—a student and alumni project. The biological sciences and the women's residences are expected to be opened this fall. The preventive medicine building, which will include the Department of Nursing, should be started shortly.

Many good examples of Indian art are located at various sites on the campus. The most recent is that carved by Ellen and Edward Neel and donated by them to the university in October, 1948. It is known as "The Thunderbird Totem" and was presented to the Alma Mater Society by Chief William Scow. You will find it just outside Brock Hall.

The University Library is well worth a visit, with its historical scenes of B.C. executed by John Innes. Its museum and art gallery are other points of interest you should not miss. You may be interested to know that this is Canada's only university library building west of Ontario. You pause in your observation to ponder. Vancouver may be irresistible, her beauty impressive, for a city so new she does aspire to much in the realms of culture. However, her poets and artists are still too few. Therefore,



Courtesy of Vancouver Tourist Bureau

The Parliament Buildings at Victoria

we can, perhaps, think of the university as a symbol of the values which her poets and painters of the future will express to us in their own inimitable way.

> To believe that there is something really great and excellent in the world, surviving all the shocks of accident and fluctuations of opinion . . . which gives immortality to human thoughts and actions, and catches the flame of enthusiasm from all nations and ages.[6]

Lovely and varied as are the attractions of Vancouver, the surrounding towns and resorts you can reach from her door-step are many. One of the finest of these is Harrison Hot Springs, reached by car or bus, a distance of about 90 miles up the Fraser. The spa itself is situated on the shores of a large lake, surrounded by mountains. A most inviting woodland path takes you in ten minutes to the natural springs of potash and sulphur. They are used for medicinal purposes by many seeking better health and freedom from various types of rheumatic conditions.

You can return by way of Chilliwack with its rich, fertile farm lands, coming eventually to New Westminster, a thriving, quaint town situated high above the Fraser. A magnificent view of mountains and river can be obtained from the Patullo Bridge, which spans the river at this point and leads to the United States border.

From Vancouver's harbor, pleasure boats go to many attractive spots located on the various bays and inlets. Bowen Island, in beautiful Howe Sound, is one of these, while Wigwam Inn at Indian River on the North Arm of Burrard Inlet is another.

Both these trips can be easily taken in a day or even an afternoon. For those wishing to go further afield and enjoy the relaxation of a lengthier sea voyage, Alaska is one of the great summer attractions. One should allow about two weeks for this very scenic and restful journey.

For a delightful week-end jaunt, the boat trips to Vancouver Island are a joy. You can go either by Nanaimo or Victoria. Many plan to make the triangle trip — take the boat to Nanaimo, motor down the Island Highway to Victoria, and return to Vancouver by boat from this demure and charming city, the capital of British Columbia. It has a leisure and beauty all its own. The pace of life is slower, and everywhere, the quiet peace and serenity of the sea.

Vancouver awaits the nurses of Canada and extends to them a most cordial invitation to enjoy all she can offer. There is a special place in her heart, not only for the newcomer, but also for those who are her own—those who return at this time to share once more the fellowship of her people and the inspiration of Nature's beauty within her gates.

Then, with your memorable visit over, you will recall—

Sounds of the seas grow fainter,
Sounds of the sands have sped.
The sweep of the gales,
The far white sails,
Are silent, spent and dead.

Sounds of the days of summer
Murmur and die away,
And distance hides
The long, low tides,
As night shuts out the day.[3]

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Note: Information on "9 o'clock gun" taken from article on Vancouver written by Miss Francis of Vancouver Tourist Bureau. 1950.

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5. Major J. S. Matthews, City Archivist of Vancouver, for his valuable assistance in reading the article for historical accuracy; also for his generosity in submitting photographs of Vancouver.

Oil of Wintergreen is Dangerous

IRENE P. THEAKSTON

About 8:00 a.m., one day last December, our two-year-old son, George, got hold of a bottle of synthetic oil of wintergreen. From the appearance of the bottle he swallowed about a half teaspoonful at the very most. I immediately gave him milk, followed by an emetic of mustard and water. After he had vomited there seemed to be no ill effects and he played about as usual. Shortly after 11:00 a.m. Georgie suddenly became cyanosed and his respirations were labored. Within 15 minutes I had him at the Children's Hospital and they immediately did a gastric lavage. Our family pediatrician said the return from the lavage was clean and did not have even a "stomachy" odor.

Georgie was then given a continuous intravenous of 5% glucose in water for 24 hours, ½cc. caffeine sodium benzoate, q. 4 h. for 3 doses, and ¼ cc. for 2 doses as a respiratory stimulant. It was not until midnight that the doctor said he was out of danger. Urinalysis the next day showed albumin plus 4 and the blood chemistry showed the N.P.N. elevated. Three days later the urinalysis showed albumin plus 2 with the N.P.N. normal. We were able to bring our son home. He was put on a low protein diet. He should have been kept in bed two or three days but, due to his usual hyperactivity, that was hard.

Apparently many people are ignorant of the danger of oil of wintergreen when taken internally. I may have a poor memory but I do not recall being taught how dangerous this medication is (although I knew it was not good for a child to drink!) and cannot recall seeing it mentioned in first aid books along with other poisons. Other nurses whom I have asked tell the same story. Even our neighborhood druggist was unaware of its dangers.

Our pediatrician explained the "delayed action." Sometimes the reaction does not occur for 6-8 hours after the wintergreen has been taken. He said there have been some very tragic results from an overdose. Although its poisonous effect is not as rapid as that of some other poisons, the general public, and especially nurses, should be taught more about the drug—its dangers, symptoms of overdosage, etc.

On the bottle's label are these words: "Poison—so labelled to comply with the law, but dosage given is perfectly safe." "Dose—10 gtt. on sugar q. 4 h." There is no skull and crossbones, nor is there any antidote printed on the label.

It only takes *one* act of carelessness to cause illness and perhaps death. We will forever thank God for sparing our little boy.

Mrs. Theakston is a 1938 graduate of the Calgary General Hospital and resides now in Halifax.

Your heart is smaller than your fist, yet it pumps enough to fill a railroad tank car every two days.

Hypertension

R. E. Beamish, M.D. *and* J. D. Adamson, M.D.
with assistance of Dorothy Low Griffin, A.R.R.C.

Average reading time — 19 min. 12 sec.

Since cardiovascular diseases are by far the commonest cause of death, and since hypertension is the commonest vascular disorder, it follows that hypertension is one of the commonest diseases encountered by the nurse both at the hospital bedside and in the home. There is probably no disease in which an optimistic, well-informed attitude on the part of the nurse is so essential to the welfare of the patient. This is because the disease is usually chronic, its victims much benefitted by reassurance, and because simple hygienic measures are most helpful in its management.

Definitions

The word "hypertension" is by common usage synonymous with "high blood pressure" and denotes increased intra-arterial pressure. The pressure during ventricular contraction is known as the systolic pressure while that during ventricular relaxation is called diastolic pressure. The abnormal elevation may affect only the systolic level but most commonly affects both systolic and diastolic readings. Systolic hypertension occurs in aortic incompetence, hyperthyroidism, heart block, polycythemia, and arteriosclerosis, and its significance and treatment is only that of the associated condition. Diastolic hypertension, however, since it greatly increases the work of the heart, is of much greater importance. It is the variety found in acute and chronic renal disease and, most important of all, in that kind of hypertension of unknown etiology called "essential hypertension."

It is important to remember that "hypertension" is only a sign, not a disease. When an elevated reading is encountered, one must carefully consider, firstly, whether or not the finding is significant and, secondly, if it is, how it may affect health and life expectancy.

Dr. Beamish and Dr. Adamson are associated with the Hypertension Clinic, Winnipeg General Hospital.

History

The association of cardiac enlargement with renal disease was noted a century ago by Bright but, of course, the mechanism of such association was unknown. With the development of the sphygmomanometer in the 1880's, the widespread occurrence of high blood pressure (with cardiac enlargement and renal damage) was realized. It was natural that clinicians of that time should attribute hypertension to a renal cause. However, as knowledge of blood pressure increased, it was noted that many hypertensives had apparently normal renal function. Accordingly, in the early years of this century, a large group of patients was separated from the chronic nephritics and a new entity, "hyperpiesia" or essential hypertension, was born. This was largely a result of the work of Sir Clifford Allbutt in England.

The cause of this condition was considered obscure until in 1934 Goldblatt again directed attention towards the kidneys. He showed that in animals a lasting hypertension occurs after partial compression of one or both main renal arteries by a metal clamp. It was thus apparent that renal ischemia could produce experimental hypertension. This started a controversy which is still going on as to whether or not hypertension in humans is of renal origin. Although prodigious efforts have been made to settle the point, and much knowledge of experimental hypertension gained, it is generally considered that experimental and essential hypertension are different and that the etiology of essential hypertension still remains completely unknown.

Factors Controlling Blood Pressure

In the normal person there are several factors which combine to maintain normal blood pressure: (1) the cardiac output; (2) the peripheral resistance; (3) the total blood volume; (4) the viscosity of the blood; (5) the elasticity of the arterial walls. In essential hypertension all of these factors are normal except the second; it is increased peripheral resistance due to arteriolar vasoconstriction which is the fundamental hemodynamic alteration in the disease. The cause or causes of this increased peripheral resistance constitutes the riddle of essential hypertension.

Wide variations in blood pressure take place in normal people during their usual activities. This is illustrated in *Fig. 1* which shows the fluctuations found in a normal youth during a quiet day at home. No physical or emotional strain occurred during the day, but still the systolic pressure varied from 105 to 135 and the diastolic from 65 to 90 in response to changes of posture, digestion, and sedentary work. If much activity, mental or physical, had been indulged in, the swing might have been much wider in range. This is a completely normal record and represents what occurs in most people.

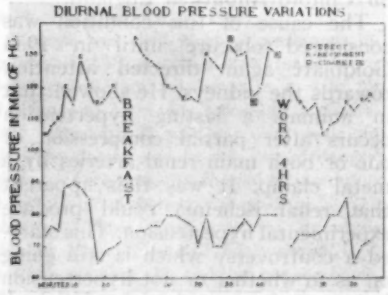

Fig. 1. Variation in blood pressure in a normal youth.

Because of these wide variations in normal persons due to emotional states, posture, exertion, digestion, etc., it has been difficult to establish the level above which a patient should be considered hypertensive. It is at once apparent that the above variations can be controlled by taking the blood pressure readings in a uniform way under basal conditions comparable to those used when the basal metabolic rate is being measured. Readings obtained under these conditions constitute the "basal blood pressure$_t$." It is generally agreed that levels exceeding 140/90 repeatedly obtained under these circumstances are abnormal and denote hypertension.

In the hypertension clinic outpatients are allowed to have breakfast prior to coming to the hospital but otherwise are handled in such a way as to obtain basal readings. Each patient is admitted to a quiet room, lies on an examining table, whereupon readings are taken over a 45-minute period. Determinations done in the same way by the same observer month after month make for better relaxation. It is not uncommon for the systolic pressure to fall 20 to 40 mm. and the diastolic to fall 10 to 20 mm. during a single visit. This emphasizes the absurdity of patients and physicians alike paying any attention to rises or falls in pressure when single "snapshot" readings are taken, either in the physician's office or in hospital clinic. Yet one commonly sees patients whose hopes rise and fall with the manometric reading —and physicians who attribute success or failure to various treatments on the same unreliable evidence.

Essential Hypertension

In the early stages essential hypertension is merely a state of accentuation of the physiological variations noted above. For some unknown reason the psychosomatic mechanism which governs blood pressure becomes more sensitive so that stimuli produce responses that are abnormally great and unduly prolonged. A condition of paroxysmal hypertension is thus produced and may last for many years. As time goes on the rises tend to be higher and the falls less until eventually there is a sustained elevation. The steady rise of systolic and diastolic pressure, with an overlay of fluctuations in a case of benign hyper-

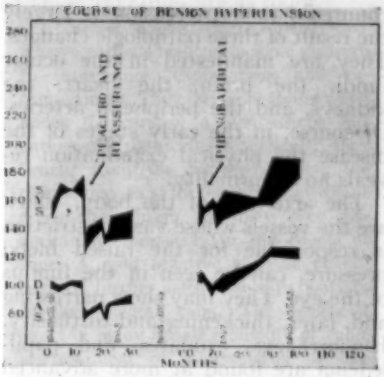

Fig. 2.

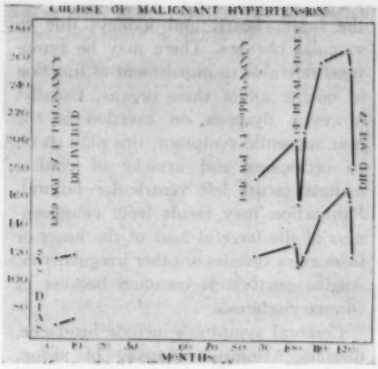

Fig. 3. Patient seen at age 27 with normal blood pressure. Again seen at age 34, pregnant and with blood pressure of 175/115. Pressure continued at approximately this level for 15 months whereupon she had a renal calculus removed. There was the usual transitory fall associated with an operation. Six months later pressure rose to 260/150 where it remained until just before death a year later.

tension observed over a period of nine years, is shown in *Fig. 2*.

Sometimes the tempo of hypertensive disease is unaccountably speeded up. Such cases, characterized by very high diastolic pressure, papilledema of the optic discs, and a rapid downhill course, are termed "malignant." In some instances, usually young adults, the disease may begin this way; in other cases the malignant phase interrupts the course of ordinary benign hypertension and brings it to a rapid close. Such an event is illustrated in *Fig. 3*.

Symptoms

There are no symptoms in hypertension due to the disease itself until the later stages. However, there are commonly three groups of symptoms in hypertensive patients[3]:

1. *Psychoneurotic symptoms:* Many hypertensive patients are "highstrung," over-active people who suffer from a psychoneurosis as well as hypertension. As a result of emotional problems and various maladjustments to their environment they complain of symptoms referable to any or all parts of the body: headaches, dizziness, inability to relax, palpitation, pain in the left chest, etc. These symptoms are invariably due to the psychoneurosis and not to the accompanying hypertension. This can be proven by treating such patients with a placebo (e.g., colored water) and noting dramatic relief of symptoms. Unfortunately, many psychoneurotics are made much worse by being told that their blood pressure is up and that their symptoms are due to this cause. Many hypertensives do not have any symptoms at all until some ill-advised physician alarms them by telling them their blood pressure is elevated and what dire consequences may befall them!

2. *Vasospastic symptoms:* Since essential hypertension is associated with constriction of the arterioles over the entire body, even in the absence of a psychoneurosis, it seems likely that symptoms may be produced solely by varying degrees of constriction or spasm. Yet it should be remembered that a blood pressure as high as 250-300 mm. systolic may exist for years without headache or other symptoms. Here we invoke the explanation that people vary in their sensitivity to disease processes. At any rate, we often find severe headaches, dizziness, nervous tension without basis, spells of flushing, etc., all of which may be intense and prolonged. Marked rises in blood pressure, with headaches, convulsion, and momentary pareses (hypertensive encephalopathy), are likely due to vascular spasm.

3. *Organic symptoms:* These symptoms develop when changes have occurred in

the brain, heart, and kidneys due to vascular changes. There may be symptoms referable to impairment of function in one or all of these organs. Usually, however, dyspnea on exertion is the first authentic symptom; this may go on to orthopnea and attacks of cardiac asthma (acute left ventricular failure). Palpitation may result from consciousness of the forceful beat of the heart or from extra systoles or other irregularities. Angina pectoria is common because of coronary sclerosis.

Cerebral symptoms include headache, dizziness, tinnitus, blurring of vision, aphasia, transient pareses, and hemiplegia or hemiparesis due to thrombosis or hemorrhage.

Renal symptoms are less prominent than cerebral or cardiac symptoms. Frequency and nocturia, due to voiding of larger quantities of low specific gravity urine, may be noted. In those cases which go on to uremia there is progressive drowsiness, weakness, gastrointestinal disturbances and, finally, coma and death.

Frequent nosebleeds and subconjunctival hemorrhages occur in some hypertensive patients.

Signs

It is still uncertain whether degenerative changes in the arterioles and arteries of hypertensive patients are the cause or the result of the disease. In any case, the clinical picture encountered in hypertension is largely the result of these pathologic changes. They are manifested in the ocular fundi, the brain, the heart, the kidneys, and the peripheral arteries. Of course, in the early stages of the disease the physical examination reveals no abnormality.

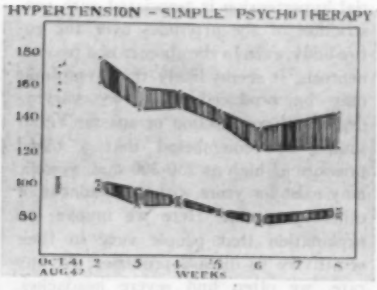

Fig. 4. Fall in blood pressure and complete disappearance of symptoms in a 42-year-old man interviewed at weekly intervals. He was given no medication except a placebo of raspberry syrup three times a day. (In this and subsequent graphs the width of curves represents the high and low readings during each period of observation.)

The arterioles of the body, which are the vessels whose vasoconstriction is responsible for the raised blood pressure, can be seen in the fundus of the eye. They may show narrowing and, later, thickening and tortuosity. Hemorrhages, exudates, and papilledema are found at more advanced stages.

The cardiac changes occurring in hypertension consist of enlargement and coronary artery disease. The enlargement at first affects the left ventricle only; later the whole heart is enlarged. Systolic murmurs are common over the apex of such hearts.

Involvement of the kidneys is revealed by the appearance of albuminuria and loss of concentrating power. Large quantities of dilute urine may be passed; in the late stages urinary output falls and nitrogenous retention occurs.

Peripheral arteriosclerosis is readily felt by palpating such arteries as the radial or brachial. The vessels are thickened, hardened, and tortuous. The pulse may be of increased amplitude in earlier cases but becomes less as arterial damage increases.

Treatment

The rational treatment of any disease is a direct attack on its cause. But only rarely in hypertension is a removable etiological agent to be found. Surgical excision of a coarctation of the aorta, an adrenal tumor, or a unilaterally diseased kidney may result in cure when these unusual conditions are encountered. In the vast majority of hypertensives, however, there is no demonstrable cause and in these there is no specific remedy. Treatment thus is far from satisfactory, yet by palliative and symptomatic measures much can be done to increase their comfort and perhaps prolong their lives. Some

common therapies are as follows:

1. *Simple psychotherapy:* Most hypertensive patients respond in some measure to reassurance, explanation, and encouragement. They feel more secure when under the care of a sympathetic but enthusiastic physician. In particular, they benefit from the knowledge that the disease may exist for many years without doing them harm and may even disappear spontaneously in the course of time. A mild sedative such as phenobarbital further assists these patients to develop mental calm. The beneficial effect of many drugs, reputedly of value in treatment of hypertension, is due in most instances to these psychic effects rather than to the medication. This is illustrated in *Fig. 4.*

2. *Rest:* Adequate physical rest is of importance to the hypertensive. This includes rest periods during the day, sound sleep at night, and sufficiently long annual vacations. Best results are obtained when physical and mental relaxation are combined. Sometimes this requires removal from the tension of the business or domestic environment to the quiet and orderly routine which ought to prevail in hospital. This effect is shown in *Fig. 5*[2].

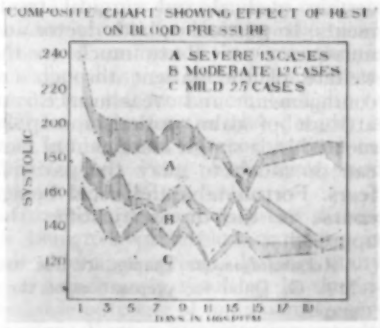

Fig. 5. Effect of rest in hospital on the systolic blood pressure of 50 hypertensive patients.

3. *Reduction in weight:* The obese hypertensive is usually much benefitted by weight reduction. Although the blood pressure may not fall appreciably, the burden on the heart is lessened and the patient always feels improved. Many diets have been recommended in the treatment of hypertension — their main value lies in the loss of weight by the obese and the restriction of salt in those in whom heart failure threatens. A beneficial result is shown in *Fig. 6.*

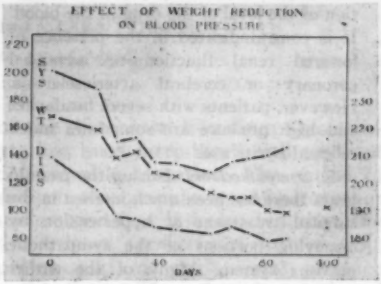

Fig. 6. Parallel reduction in weight and blood pressure in an obese man of 49. Some psychotherapy no doubt contributed to the effect although no conscious effort was made in this direction.

4. *Thiocyanate:* Most of the drugs used in hypertension depend on psychic effects; the most important exception is thiocyanate. This drug is capable of reducing blood pressure and relieving symptoms to a degree beyond that effected by placebo therapy[4]. This can be demonstrated by having patients alternately on and off thiocyanate without their knowledge so that the psychic factor is controlled. *Fig. 7* illustrates repeated falls in blood pressure when thiocyanate was given, followed by rises in pressure when a placebo mixture of similar color and taste was substituted.

Although useful in selected cases, thiocyanate has not a wide application

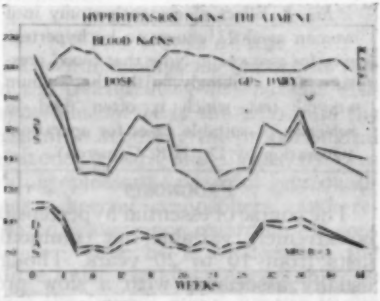

Fig. 7. Effect of thiocyanate on blood pressure. The top curve represents the blood level of the drug; the middle and lower curves the systolic and diastolic pressures respectively. Where blood pressure curves are hatched, the drug was being given; where the curves are plain, the placebo was administered.

because it is toxic and dosage must be carefully controlled by periodic estimation of the level of the drug in the blood. It is contraindicated in the presence of lowered renal function or advanced coronary or cerebral arteriosclerosis. However, patients with severe headaches and high pressure are sometimes much relieved by its use.

5. *Sympathectomy:* During the past 25 years there has been much interest in the surgical treatment of hypertension by removing portions of the sympathetic nervous system. Many of the earlier reports were overly enthusiastic and the operation thereby discredited. There is now no longer any doubt that it is of value in a few properly selected cases. It should be considered in severe progressive hypertension, especially in patients below the age of 50. A good effect is shown in *Fig. 8*.

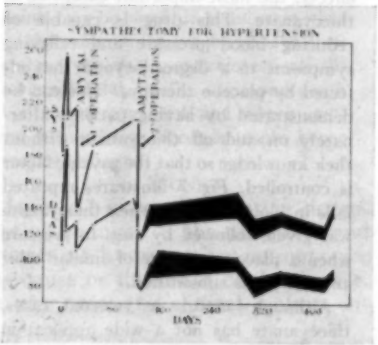

Fig. 8. Effect of sympathectomy in a woman aged 23 known to be hypertensive for two years. Note that blood pressure fell strikingly with the sodium amytal test which is often used in selection of suitable cases for operation. (Operation by Dr. H.F. Cameron)

Prognosis

The course of essential hypertension is extremely variable but commonly lasts from 10 to 20 years. Though usually associated with a slow progressive degeneration of the arteriolar system, long remissions may occur for no apparent reason and occasionally these are permanent. Unfortunately, as already pointed out, the disease sometimes behaves in the opposite manner and runs a rapid and destructive course.

It is important that all those participating in the management of hypertensive patients realize that prognosis is not dependent on the height of the blood pressure alone. Some patients tolerate very high pressure for many years with little ill effect, while others suffer serious disability after only a few years of moderate elevation. It is for this reason that it is desirable to educate patients away from reliance on their actual blood pressure figures.

Elevation of blood pressure is one of the commonest signs met with in clinical medicine. If the diastolic pressure is persistently raised when taken repeatedly under resting conditions, a thorough search for an underlying cause must be made. Usually none is found and a diagnosis of essential hypertension can be established. It is then necessary to determine to what extent, if any, the arterioles and vital organs (heart, brain, kidneys) have been damaged. Review of these from time to time indicates whether or not the disease is progressive. The course of the disease is favorably influenced by several simple measures as well as by certain medical and surgical treatments. In particular, both doctor and nurse can contribute much to the welfare of the patient through encouragement and reassurance. An attitude of calm optimism, supplemented by a simple statement of fact, can do much to allay the patient's fears. Fortunately, the usual benign course of the disease justifies this approach.

Acknowledgement: Thanks are due to Miss G. Dubo for preparation of the graphs.

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Nursing the Hypertensive

MARGRET SIGMUNDSON *and* CLARA EINARSON

Average reading time — 11 min. 48 sec.

HYPERTENSION, the commonest and most important of all heart diseases, causes more deaths than cancer and tuberculosis combined. Six people out of ten, reaching the age of 65 in good health, will die from diseases that are associated with high blood pressure.

There are two types of hypertension, namely—benign and malignant. The malignant variety is of relatively short duration, the average prognosis being about two years from the time of the first symptom. It is characteristic in its rapidly fatal course, its protean manifestations with signs and symptoms of damaged retina, faulty kidney function, generalized arterial spasm, and rapidly enlarging heart. Eighty per cent of cases occur in people under 45.

Because of the nature of the disease and the necessity of extensive laboratory and x-ray procedures to evaluate a case suitable for therapy, the treatment of malignant hypertension is always a hospital procedure. A treatment for this condition, brought to the front within the last decade, is the lumbodorsal sympathectomy as devised by Peet, Smithwick, and others.

In contrast to this is the disease of benign hypertension occurring in an older age group, lasting many years and rarely resulting in the inevitable outcome of malignant hypertension. Benign hypertension, nearly always associated with arteriosclerosis, produces fatal complications in the form of cerebral or coronary artery thrombosis.

THIOCYANATE

In more recent years the treatment of the disease with sodium thiocyanate has been introduced and received considerable attention. The action of sodium thiocyanate is not altogether understood but it is known that the drug is a powerful, protoplasmic poison and, as such, may produce toxic effects. These largely consist of anorexia, nausea and vomiting, erythematous dermatitis, and changes in bone marrow.

The dosage necessary to maintain effective blood concentration varies. Blood levels must be done weekly until the maintenance dose has been ascertained. Monthly levels must be continued, due to the occasional case with a long interval between the first administration and the signs of toxicity. If the treatment with sodium thiocyanate is to be followed, important considerations are: a complete clinical and laboratory assessment of the patient, administration of the drug as ordered, and some knowledge of its toxicity. It is evident that the nurse, with her more constant association with the patient, must be aware of the toxic effects and watch for any symptoms.

THE NURSE'S PART

The nurse plays an important role in the treatment of any patient with hypertension. It is she who aids the patient in attaining the proper mental attitude toward his illness by providing pleasant, peaceful surroundings, cheerful atmosphere, and repeated reassurance regarding his condition. While he is in hospital, the nurse must use every opportunity to help the patient adapt his life to his disease, without stressing his illness to the point where he considers himself a permanent invalid. It should be pointed out that he may lead a long and useful life provided he avoids all excesses. Moderation in exercise, eating, drinking, and smoking; freedom

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from worry; rest and complete relaxation are the prime factors to be considered.

When he first hears of all these restrictions, the patient is likely to become depressed and discouraged, and needs detailed explanations as to just what each one implies.

1. *Freedom from worry*, the most important item, is one of the most difficult to secure. The patient is concerned with his own welfare, with being a burden upon others and, in the case of most family men, with financial worries. He should be told how many persons, in the same predicament, have been able to adjust their work so that they could carry on a relatively normal business life. The necessity of avoiding all emotional strain, such as excitement, fear, and tension, must be equally emphasized.

2. *Rest*, which is always stressed so much in hospital, must become part of the daily routine. The patient should be taught the value of resting a half-hour or more after each meal and, if possible, lying down in complete relaxation for at least an hour every afternoon. Adequate sleep is essential to the patient's well-being, eight to ten hours being the minimum requirement.

3. The education of the individual as to the *kind and amount of exercise* he may take is important. Although his activities must of necessity be curtailed to some extent, reasonable exercise is beneficial. The amount of exercise advisable is best regulated by the patient's own tolerance for it.

4. *Proper diet* is essential. Frequent light meals are preferable to three heavy meals per day. The obese patient benefits greatly by a reduction in weight with a general limitation in diet. All patients with hypertension need to limit their meat consumption but plenty of fresh fruit and vegetables are desirable as these tend to combat constipation.

5. The *use of alcohol and tobacco* should be limited but it is unnecessary to advise complete abstinence. This only causes undue strain on the patient and is then likely to be disregarded.

6. *Recreation* is a necessary part of everyone's life and is of vital importance to the hypertensive. Sports or hobbies requiring a moderate amount of exercise provide relaxation and prevent the patient from considering himself an invalid, unable to partake of the activities of normal people.

It is equally important that the family be made to realize the necessity and reason for all these restrictions, that they may supplement the efforts of the nurse in gaining the patient's cooperation. Upon the patient's discharge from hospital, the family must assume the responsibility of helping him to adjust to his modified regime. Only when they comprehend the nature of the disease and its inherent dangers are they able to do so.

Case History

Mr. Lee, a 65-year-old retired railway man, with benign hypertension, had been attending the out-patient department for several years with complaints of dyspnea on exertion and swelling of the ankles by the end of the day. In addition to this, he was aware of increasingly severe and frequent headaches and dizzy spells. By this time, his blood pressure was 210/110 and he was admitted to hospital for investigation and treatment of his symptoms.

Mr. Lee was a heavy-set, red-faced, white-haired man. He was a cooperative patient, cheerfully complying with all restrictions of exercise, excitement, and diet. He showed an intelligent interest in and understanding of his condition.

For the first three weeks in hospital, treatment consisted of bed rest and mild sedation in the form of phenobarb. gr. ½ t.i.d. On this, he showed considerable subjective improvement although there was little change in blood pressure. In view of this, sodium thiocyanate treatment was considered and the necessary laboratory tests done to determine whether or not he was a suitable candidate. Urea clearance showed a mean function of 48%; specific gravity of urine in urine concentration test was 1.020. Electrocardiogram revealed left ventricular strain.

For two weeks Mr. Lee was given to believe that treatment had been started whereas he received a placebo medication which had the appearance and taste of the actual drug. This was done to determine the extent of any psychological

effect the medication might have. Mr. Lee showed no appreciable change in condition throughout the test period. By the end of the first week on sodium thiocyanate he was nauseated and felt weak so the dose was reduced and all toxic symptoms disappeared. He continued on sodium thiocyanate, phenobarb., and limited exercise for a month.

Because of his cheerful, optimistic nature, nursing care was minimized. Although he was confined to bed most of the day, Mr. Lee kept himself occupied and content with his leatherwork, which had long been his hobby, and the ever-present detective novels supplied by the hospital library. He was given a light ward diet with milk and biscuits between meals. As in the case of all cardiacs, the care of the bowels was important, it being necessary to avoid the dangers resulting from constipation and straining at stool. In view of this, he was given mild purgatives or a saline enema every third day. Frequent care of his back was given to prevent the pressure sores which may occur in an elderly patient on bed rest. Throughout the course of treatment, daily blood pressure readings were taken and showed a decrease from 210/110 to 175/95. When he left hospital two months from the time of admission, Mr. Lee "felt like a new man." He was instructed to report to the out-patient department so that treatment could be continued and followed.

Sympathectomy

The nursing problem for a case selected for sympathectomy is quite different in form. The general measures are equally as important as the medically treated case, if the patient's hypertension is to be evaluated. Preoperatively, several laboratory tests, including the blood urea nitrogen, urea clearance, and urine concentration are done to determine the extent of the renal impairment. In the urine concentration test, fluids must be restricted from 4:00 p.m. until the specimens are collected at 6:00 a.m. and 7:00 a.m. Similarly, the entire value of the urea clearance is dependent upon the time and the amount of urine passed. In an effort to determine the lability of the blood pressure and, indirectly, the suitability of patient for operation, the sodium amytal depressor test may be done. To obtain optimum results, the patient must be at rest mentally and physically and the surroundings be as quiet as possible. It is the nurse who is in large part responsible for the accuracy of these tests.

Case History

Mr. Stein, a 37-year-old Jewish immigrant from Germany, was admitted to hospital for investigation and treatment of his headaches. He complained of severe, penetrating, occipital headaches, recurrent nosebleeds, and blurring vision for the past three months.

Physical findings revealed a blood pressure of 210/140, a markedly enlarged heart, and grossly abnormal eye-grounds with swollen discs, arterial spasm, patches of exudate both old and new, and enlarged retinal veins. Sodium amytal sedation test revealed a drop in blood pressure from 210/120 to 115/80. Further investigation showed a urine concentration of 1.024 and a blood urea nitrogen of 18 mg.%.

It was thought that Mr. Stein might well benefit from a lumbodorsal sympathectomy. After some discussion and consultation with the family, he consented to surgery.

Mr. Stein was a nervous, apprehensive individual, constantly worrying about the state of his health. His family was unable to improve his mental attitude. They were equally as worried and excited over his condition and required as much reassurance as the patient himself. On several occasions, after visiting hours, Mr. Stein was seen aimlessly pacing the corridor in a state of agitation. Given the opportunity to talk about himself, his condition, and the treatment he was to receive, he became more relaxed.

In the course of his investigation, it was discovered that his hemoglobin was only 62%. He was given two blood transfusions pre-operatively, bringing it up to 76%. The operation performed was a right lumbodorsal sympathectomy, entailing the removal of nerve and ganglion tissue from T5 to L4. His immediate post-operative condition was satisfactory. Routine orders, consisting of active and

passive movements, deep breathing, and change of position, were carried out. Demerol 100 mg. was given p.r.n. for pain. Fluids were encouraged and intravenous fluids given to supplement his oral intake for the first few days. Blood pressure was taken frequently and was found to fluctuate between 244/144 and 188/105. Mr. Stein continued to improve steadily and, before long, had increased his activities from dangling to walking about the ward. Chest plate prior to discharge revealed a pleural effusion, one of the commonest complications of sympathectomies. He was discharged eleven days after operation with a blood pressure of 218/118.

Three weeks later Mr. Stein was readmitted for the second stage of his sympathectomy. He was not as nervous or apprehensive as on his previous admission. Chest plate showed the pleural effusion to be resolving. He was slated for surgery three days later when a left lumbodorsal sympathectomy, with the removal of nerve and ganglion tissue from T6 to L4, was done. Post-operative treatment was primarily the same as for his first operation. At times he was very apprehensive and required a great deal of reassurance. On the third post-operative day he was allowed up but, before getting up, a scultetus binder was applied and elastocrepe bandages to both legs. Exercise tolerance was rapidly increased and the post-operative course was uneventful. On discharge his blood pressure was 165/100 and symptomatic results were excellent.

As shown by the very satisfactory results obtained in these two cases, it is evident that much can be done to relieve the suffering of the hypertensive patient.

Although these are only two of the many treatments used in the treatment of hypertension, they have been found to give the most satisfactory results in selected cases. Many patients are benefitted by simpler measures.

The nation is rapidly becoming more health conscious. It is to be hoped that, through routine physical examinations, diagnosis will be made earlier, for success in therapy is dependent on treatment being initiated before vital organs are too severely damaged.

Public Health Nurse's Role with the Hypertensive

SUZANNE PETURSSON

Average reading time — 5 min. 12 sec.

WHEN WE REALIZE that 25 per cent of all people who die after the age of 50, die as a result of the effect of hypertension, we can see that the disease constitutes a major public health problem.

The public health nurse thinks of the disease in two aspects—first, the hypertension which has not progressed to the point where it has produced serious organic changes in the body; and, second, hypertension which is well established and has markedly damaged the arteries, kidneys, and more frequently the heart.

In working with patients suffering from the disease the public health nurse gives nursing care in the home where necessary. Of equal importance is a service which is often overlooked. This is the help which she may give the patient and his family in adapting the home situation to provide rest and freedom from anxiety for the patient while, at the same time, she tries to restore him to his greatest economic efficiency. This seems like a large undertaking but is very essential when we realize that lack of care may

Mrs. Petursson is a staff member of the Victorian Order of Nurses in Winnipeg.

result in death or chronic invalidism fairly early in life. With adequate treatment and a regime of moderate living the majority of patients tolerate hypertension fairly well.

In the other articles dealing with this topic, it has been shown how bed rest and the removal of the patient from a distressing home atmosphere usually decrease the blood pressure. Conversely, a patient's condition may deteriorate if, after dismissal from hospital, he returns to a home where he is overworked and under pressure of mental stress.

Cooperation between the doctor, nurse, and patient's family is necessary to determine to what degree the patient must moderate his life. The nurse needs instruction from the physician as to the gravity of the patient's condition and the extent to which he may resume former activity. The nurse, who is often more familiar with the patient's home situation and the existing community facilities which may offer aid, can cooperate with the family in assuring a proper regime for the patient.

To the patient this moderation of activity is usually distressing. Encouragement to rest must never be allowed to be interpreted as encouragement to idleness. Chronic illness carries with it a heavy toll of mental lassitude. The patient must be kept mentally and, as far as possible, physically active. It is of little value to attempt to increase a patient's lifespan if he is to be made to feel a burden on his family and community.

The public health nurse hopes to find the hypertensive patients in her district soon after they are diagnosed and helps to make the period of adjustment easier for the patient and his family. The following case study will illustrate specifically what the nurse hopes to accomplish.

Case History

In 1946, Mr. and Mrs. Bird, with their two youngest children, lived on a farm in rural Manitoba. At this time the heavy work appeared to be too much for Mrs. Bird who was now 49 years of age. The family sold their farm and moved to Winnipeg. Here Mr. Bird had difficulty in finding regular employment, so the family used their savings to buy a large rooming-house. This provided a small but regular income and the work of the household was largely Mrs. Bird's responsibility.

Since the birth of her youngest son nine years before Mrs. Bird had had no medical contact as there was neither a doctor nor health unit in their rural locality.

The Victorian Order nurse met Mrs. Bird when making a visit to one of the tenants in the rooming-house. She complained to the nurse that she had had a severe cold for a month, a cough that kept her awake at night, and shortness of breath. In addition, her ankles were edematous and she complained of a small urinary output.

The nurse suggested she visit the medical clinic for a physical examination and Mrs. Bird agreed to do so. Here she was diagnosed as hypertensive with cardiac involvement. Hospital care was advised and the nurse directed Mrs. Bird to a social agency which agreed to provide housekeeping service for her family during her period of hospitalization.

In hospital Mrs. Bird was treated with mercurials, thoracentesis, and bed rest. Before dismissal she was advised to report to the hypertension clinic every two weeks and the V.O.N. was requested to give Mrs. Bird 2 cc. salyrgan twice weekly at home.

On return from hospital she appeared much improved. She had lost 18 lb., her edema was less, she appeared more rested and was anxious to resume normal activity as soon as possible. The doctor had ordered a moderation of activity and when the situation was explained to Mr. Bird he wrote to an elder daughter who agreed to return home to assume some of the responsibility of the household. So as not to unduly alarm her regarding her illness, the nurse discussed ways of relieving Mrs. Bird of some of her household duties with the family.

Mrs. Bird was encouraged to continue any work which did not entail too much physical activity. She was taught to keep an accurate recording of her weight and to lessen her fluid intake. The doctor had advised a reduction in weight and

the nurse gave Mrs. Bird a table of caloric values and suggested food substitutions to make her diet more palatable. Through the past three years Mrs. Bird has occasionally needed to be readmitted to hospital for complete bed rest for periods of approximately 10 days. This was due to a more marked increase in blood pressure. It is interesting to note that these periods occurred at times of strain in her family life—during the illness of a son, during long periods of unemployment of her husband.

Prolonged treatment and these periods of hospitalization resulted in financial hardship for the family. The nurse directed the family to the city Social Welfare Agency which agreed to provide Mrs. Bird's medication free of charge and pay part of the cost of her hospital care.

It can be seen that much remains to be done in the public health field. There is a great need for expanding diagnostic and treatment facilities in rural areas. The benefits received by the individual and the state, through early diagnosis of potentially chronic diseases, are substantial. For this reason regular physical examinations should be made available to all.

The greatest difficulty the public health nurse meets in working with hypertensive patients is finding these patients early. The service which she can offer in the home is not often recognized until the patient actually needs bedside care. It is hoped that the day will soon come when doctors and patients will call her early so that she may give more adequate care and so help to rehabilitate the hypertensive patient with little delay.

Who is Responsible?

AGNES J. MACLEOD

Average reading time — 4 min. 6 sec.

SO OFTEN I hear the statement "Why doesn't someone do something about it?" or "What is the C.N.A. doing about this?" or "What is the provincial nurses' association doing about that?"

I would like to discuss briefly a very important professional problem which is facing every nurse earning her livelihood in the practice of nursing in Canada. Who should evaluate and accredit our Canadian schools of nursing?

Each one of us graduated from some one school of nursing. If we are honest, thinking individuals, we must all admit that there were some things wrong with our professional nurse preparation. No school in Canada, which is conducted by one hospital, has yet been able to give to its student nurses sufficiently planned, integrated, broad or complete nursing educational programs to satisfy fully the criteria for professional education.

Certain faults of schools of nursing stand out more starkly than others. For one reason or other, hospital boards, school of nursing committees, hospital medical and nursing administrators, as well as directors of schools of nursing and instructional nursing staffs, continue to cling to the old order, glorify their particular traditions, and deplore any departure from the present hospital-controlled school of nursing tie-up which exists across our country.

Graduate nurses themselves are too complacent and, through lack of awareness or lack of interest, as well as preoccupation with their personal affairs, neglect their professional obligations and seem to think that it is someone else's concern that our present system of nurse training is not providing sufficient well-trained nurses to meet the health service needs of Canada. For years the few conscien-

As chairman of the C.N.A. Educational Policy Committee, Miss Macleod has taken a very active interest in sponsoring this vital program.

tious nurses have carried the load for the many. Yet, because of the complacency of the many, the few are not able to achieve all the reforms that are needed to improve our schools of nursing.

Canadian schools of nursing need to be evaluated and accredited. Yet, because of lack of large enough affiliation fees to the C.N.A. from every nurse working in this country, the Canadian Nurses' Association, although recognizing the need for accreditation, has not been able to finance such an undertaking so far.

Now that our demonstration school —the Metropolitan School of Nursing in Windsor—has graduated its first class of students in 25 months, it is imperative that Canadian nurses at least have an opinion as to whether this new principle of nursing education—"that nurses can be better prepared in a shorter period of time, in a controlled educational situation" —is sound or not. Many experienced nurse educators believe it is sound.

But we need a system of evaluation, whereby all schools of nursing can be judged and helped to improve their present deficiencies. Later, in fact one educator claims it would take six or seven years, we need to establish a system of accreditation for schools of nursing. Poor schools should not be allowed to continue indefinitely.

What is being done in Canada to bring about such an Evaluation and Accreditation program? To answer that question, our editor requested me to write this article as the final one of the series dealing with Evaluation and Accreditation appearing in *The Canadian Nurse* this spring. If, by chance, you have missed these articles, I would suggest that it is the *responsibility of every nurse in Canada to know* what has already been done along these lines in Canada and the United States. I would refer you to your *Canadian Nurse* for:

1. February, 1950, page 112. Editorial: Evaluation of Schools of Nursing.
2. March, 1950, page 187. Margaret M. Street: Accreditation of Educational Programs in Nursing.
3. April, 1950, page 278. Sr. Denise Lefebvre: Evaluation of Schools of Nursing.

In this last article you will see how far the Nursing Sisterhoods of the Canadian Conference of Catholic Schools of Nursing have progressed.

During this biennium, the C.N.A. Committee on Educational Policy has studied the problem of how we can best institute a program of evaluation and later establish an accreditation system for Canadian schools of nursing. In order to secure advice and knowledge on how we should proceed, Miss Margaret Street was appointed convener of a small sub-Committee on Evaluation which has met several times. The members of this subcommittee are acting as the nurse consultants for the Work Conference on Evaluation and Accreditation of Schools of Nursing at the C.N.A. Convention this summer. Sister Denise Lefebvre, s.g.m., M.Sc., is a nurse educator of distinction and is considered a real authority on this subject by everyone who knows her. We are fortunate to have her as the chief consultant at the work conference. It is hoped that everyone registering for this work conference will enter into the program whole-heartedly.

We believe that before the Canadian Nurses' Association can launch an evaluation program there must be another person at National Office whose responsibility it would be to travel, arrange, and conduct area institutes on, and eventually help set up the machinery for such an evaluation program. Consequently, the Executive Committee accepted the recommendation for discussion and decision at the meetings in Vancouver—that an educational secretary should be appointed to National Office. *It is your responsibility to vote on this resolution in June.*

If the C.N.A. decides to appoint an educational secretary, we will hope that before long our national evaluation program can be initiated.

The Hawaiian alphabet consists of only 12 letters—less than any other language in the world.

Nursing Profiles

Laura Holland, C.B.E., R.R.C., can now add another impressive set of initials to her name. At the annual convocation of the University of British Columbia on May 12, Miss Holland received the honorary degree of Doctor of Laws in recognition of the outstanding contributions she has made in the social welfare field. Best known for her service in this area, it is, nevertheless, a matter of pride to the nurses of Canada that she has never been too busy nor too engrossed in her social work activities to participate actively in professional nursing affairs. Thus we echo the congratulations of our social work colleagues in acclaiming Miss Holland.

Born in Montreal, Miss Holland deserted a promising musical career to enter the school of nursing of the Montreal General Hospital where she graduated in 1914. After a year in private nursing, she joined the C.A.M.C. and served with distinction in England, France, Salonika, and Lemnos.

Returning home, Miss Holland decided to broaden her training by studying social work at Simmons College, Boston. After a year as social worker in the V.D. clinic at M.G.H. she became director of nursing services with the Ontario Red Cross Society. In 1923, she became manager of the Welfare Division of the Toronto Department of Public Health. She moved to Vancouver four years later to undertake the re-organization of the Children's Aid Society. Her field of influence was broadened in 1931 when she took over the functions of the superintendent of Neglected Children for the province. When she became supervisor of the B.C. Welfare Field Service her far-seeing judgment enabled her to lay the strong foundation on which this service now functions. Immediately prior to her retirement in 1945, Miss Holland was adviser to the Minister on Matters of Social Welfare Policy.

LAURA HOLLAND

Miss Holland's great gifts of knowledge, technical competence, and administrative skill have brought her public recognition. These would all have been barren if it had not been for her warmth of personality, her personal kindliness and understanding, her spirit of altruism and her devotion. Her example will continue to shed a glow across both nursing and social work in the years to come.

Edna E. Andrews, a Manitoba-born nurse who saw front-line service during World War II, has been elevated to the top feminine medical post in the Canadian Army. As Matron-in-Chief, Royal Canadian Army Medical Corps, Major Andrews succeeds **Major (Principal Matron) Dorothy F. Ballantine** who has held the post since 1946.

Major Andrews graduated from the Saskatoon City Hospital in 1931. Later she undertook post-graduate studies at the Royal Victoria Hospital, Montreal. She enlisted with the R.C.A.M.C. in 1941. She was assistant matron at No. 6 Canadian General Hospital during the campaign in Northwest Europe. Later, she became Capt./Matron with No. 16 C.G.H. In 1945 she was made an Associate of the Royal Red Cross.

Following her return to Canada, Major Andrews served at the Calgary Military Hospital and with a detachment of the Northwest Highway System. From June, 1946, until her present appointment she was attached to the Toronto Military Hospital.

Evelyn Florence Matheson has been chosen to receive the Thomas Wall Scholarship awarded by the Canadian Nurses' Association on behalf of the British Common-

wealth and Empire Nurses War Memorial Fund. Miss Matheson plans to enrol next autumn at Teachers College, Columbia University, New York, for post-graduate work in school of nursing administration.

Born in Pithapuram, South India, the daughter of a Baptist missionary, Miss Matheson came to Canada during her 'teens and secured her Bachelor of Arts in 1941 from Acadia University, Wolfville, N.S. She entered the school of nursing of the Toronto General Hospital, graduating in 1944. She went to work immediately at T.G.H. as medical float, assisting the night supervisor. At the end of a year she was made an assistant head nurse. Three years later, Miss Matheson decided to engage in private nursing for a time. In February, 1949, she joined the general floor duty staff at Sunnybrook (D.V.A.) Hospital, Toronto.

EVELYN MATHESON

Mildred Dobbs, who for over 38 years has been nurse-in-charge of the Lethbridge Isolation Hospital, has retired. A native of Gloucestershire, Miss Dobbs began her nursing career among the poor in English slums. The urge to come to Canada seized her after many conversations with Canadians and watching ships leave for the New World. She finally succumbed to the lure and arrived in Lethbridge in the autumn of 1911. She began working at the Isolation Hospital and has been there ever since with only five days' sick leave in all that time. Miss Dobbs has returned to her homeland twice but has never had a desire to go back there to live.

Tribute was paid to Miss Dobbs's long years of faithful and humanitarian service by the City Council on the occasion of her retirement. Her kindly and efficient care has brought cheer, comfort, and healing to young and old who have been patients at that hospital. Miss Dobbs retires with the warm appreciation and good wishes of her fellow citizens.

Etta McLeay, who graduated from the Hamilton General Hospital in 1906, and who for 44 years has given devoted service to her patients, has retired. Miss McLeay went west in 1911 after several years of duty in the tuberculosis sanatorium in Hamilton. She opened and operated Harbor View, a private hospital in North Vancouver and later Chatham House Private Hospital in Vancouver. She plans to live in Ontario.

In Memoriam

Charlotte (Foster) Bean, who graduated from Royal Victoria Hospital, Montreal, in 1936, died on March 29, 1950, at New Mills, N.B., following a lengthy illness. Mrs. Bean was on the general nursing staff of the Ross Pavilion for several years prior to her marriage.

* * *

Caro Clark, who graduated from the Lady Stanley Institute, Ottawa, died in Hamilton on March 31, 1950. She had been in ill health for about a year. Miss Clark had served as superintendent of nurses at the Mount Hamilton Hospital from the time of its opening in 1917 until her retirement in 1938.

* * *

Jessie Alexander Connal, R.R.C., who had served as nursing instructor at Calgary

General Hospital from 1920 until her retirement in 1948, died on April 5, 1950, in Calgary. A graduate of the Royal Infirmary, Glasgow, Miss Connal served overseas for six years with the British Expeditionary Force. She was twice mentioned in despatches and was awarded the Royal Red Cross medal for her services.

Jacqueline Phillips, a member of the 1951 class of Saskatoon City Hospital, was killed in the crash of a plane near Saskatoon on March 29, 1950.

* * *

Roe A. Spooner, who graduated many years ago from St. Luke's Hospital, Ottawa, died in Kingston, Ont., in April, 1950.

In The Good Old Days

(*The Canadian Nurse, June 1910*)

"There has been up to within very recent years little or no practical idealism in hospital planning . . . The great question to be considered is that a hospital is a 'living thing' which must be supple as well as graceful; it must be a means to an end rather than the end . . . Peculiarly, those who are building a hospital are not the final arbiters of the ultimate size to which this hospital will attain. Most men . . . have rigidly fixed ideas that their hospital shall not contain more than just as many beds as its ultimate capacity. They give no thought to the growth of towns; they give no thought to the fact that people are becoming more and more educated to the hospital idea . . . They give no thought to the fact that, when their institution is full and they are running to their utmost capacity at all times with more patients clamoring for admittance . . . this condition gives birth to a mushroom growth of badly planned and poorly constructed hospitals — a menace and a detriment to any growing community."

* * *

"Does the average medical practitioner do his duty to his faithful nurse? Does he properly appreciate the value of her assistance to him? Does he take the trouble to ascertain the amount of work she does and the time she spends in looking after the patients?

"We hold a fixed opinion that it is the duty of the physician to know as far as possible what the nurse is doing. It is surprising what a nurse will frequently endure while caring for her patients. The physicians should see to it that the strain in such cases will not be unreasonably prolonged. We do not propose to lay down a set of rules for the doctor. When, however, he has as his assistant a good nurse . . . he should show her some kindly consideration."

* * *

"An important event, not only in nursing circles, but in regard to the interests of the city of Toronto as a whole, has just taken place. The Board of Education has appointed Miss Lina L. Rogers . . . as supervising school nurse for Toronto. Two assistants have also been appointed — Miss Jamieson and Miss Robertson."

* * *

"In March several cases of smallpox occurred in Port Arthur, Ont., including a patient and a nurse from the new R.M. and G. Hospital, also the medical health officer, his daughter, and two members of another family. All have recovered."

* * *

"A pleasing and popular feature of the occasion (*graduation, R.V.H., Montreal*) was the presentation by Mr. Angus, on behalf of the Governors, of an R.V.H. graduate's badge to Miss Felter, thus making her an honorary graduate of the school. Miss Felter, although not an R.V.H. graduate, has had charge of the operating department for several years, and the badge was presented to her as a mark of appreciation of her work in the hospital. It is the first time such an honor has been conferred by the hospital."

Good Hearing Helps

Before a child is condemned for inattention at home and school, make sure his hearing and eyesight are up to par. Poor hearing, particularly, is often mistaken for carelessness and even stupidity. Medical attention, rather than discipline, may be what he needs.

Institutional Nursing

Post-Anesthetic Recovery Rooms

ELVA HONEY, B.N.

Average reading time — 15 min. 24 sec.

ARE YOU THE SUPERVISOR or head nurse of a surgical ward? Perhaps you are the director of nursing in a general hospital. In either case you are all too familiar with the dilemma that can arise when, just at dinner-time, several patients return to the ward from the operating-room. The thought that went into planning nurses' hours off duty, meal-times, and preparing equipment in advance often seems of no avail when even just one of the operative cases requires emergency resuscitation, skilled personnel, and highly specialized equipment. Chaos arises when these essentials are not available at a moment's notice.

How can the ever-increasing number of surgical patients be ensured safe post-anesthetic care when there is a shortage of nurses and the cost of special equipment limits its supply?

What happens in many general hospitals today? Mr. Smith, who has had a lobectomy, is returning from the operating suite to his room at the other end of the hospital. Elevator service is slow. It is just noon and the staff are en route to the dining-room. Patients are going to and from the x-ray department. Medical students are hurrying to their next lecture. A group of visiting nurses is already in the elevator; chatting, they do not immediately hear "one side, please." Some have to step off the car to make room for the bed and those attending the patient. A transfusion is in progress and through all the delay the patient's need for oxygen is increasing. Eventually he reaches his own ward.

Miss Jones, the nurse in charge, the only one with experience in caring for this type of operative, is doing her best to ensure that the four other post-operatives of the morning, as well as the remaining patients on the ward, are receiving the required care. She is overwhelmed with worry and work. More so now, as she discovers that Mr. Smith's transfusion has stopped. Obviously the needle became dislodged as he journeyed from the operating room. Something is wrong with the oxygen equipment, just when all possible care had been taken to have everything in readiness for Mr. Smith's return. That old-style, worn tent should have been replaced long ago but the new, convenient ones are so expensive.

Miss Jones calls the interne. He is in some far-off corner. Likewise, the anesthetist, still busy in the operating room, is too distant to be of immediate help to Mr. Smith. After a lapse of considerable time the interne appears, accompanied by the surgeon. They finally succeed in restoring order but not without further delay in obtaining oxygen equipment, transfusion apparatus, stimulants, and so on. As one can see, an avoidable delay has occurred which might easily have been fatal. Everyone wants to help but no one helps properly.

Difficulties, similar to those just related, arose during the war when field hospitals were frequently inundated with patients in serious hemorrhagic, neurogenic or traumatic shock. Here was only a small staff of doctors, nurses, and orderlies; specialized equipment was at a premium. The

Miss Honey is Montreal Area nursing consultant with the Department of Veterans Affairs.

medical authorities agreed that the obvious solution to the problem was to centralize personnel and materials. So came into being the "Resuscitation Ward," which proved to be one of the good things to come out of the war. Patients arriving at a Casualty Clearing Station, for instance, were often in such poor condition that immediate operation was out of the question. They were grouped in the large resuscitation ward (tent or room as the case might be) where pre-operative care was given. When the surgeon and anesthetist considered these patients ready for operation they were taken to the adjacent operating room or tent for surgery. This over, they were returned to the resuscitation ward where the small but expert staff did wonders with the limited equipment allotted a C.C.S. What was available was right at hand.

Does this give a clue as to how the present plan of post-anesthetic care of patients in hospitals could be improved? Yes, indeed! The idea of centralization remains unchanged even though the familiar setting of long rows of canvas stretchers, mounted on trestles crowded up and down a hospital tent, gives way to a well-equipped, well-organized ward now bearing the name *post-anesthetic recovery room.*

Ideally, this room is part of, or adjacent to, the operating suite, is near the blood bank and large enough to accommodate two beds for each operating theatre. One bed is for the patient about to be operated upon, the other for the patient whose operation is just completed. In this room are to be found drugs and apparatus required to meet the needs of any emergency resuscitation. The personnel assigned for duty in this department must have intensive training and concurrent actual experience in preventive and curative resuscitation measures in order to be thoroughly familiar with the various signs and symptoms of shock and anoxia and to know what to do to keep the physiologic functions—respiration and circulation—as nearly normal as possible.

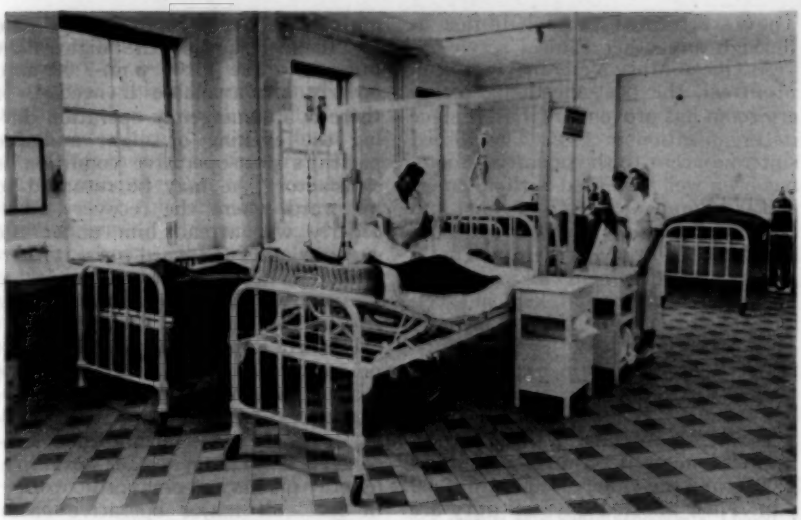
The name post-anesthetic recovery room is perhaps misleading for it is advantageous to have the patients brought to this ward pre-operatively as well. The nurse has an opportunity to observe the patient before he is under the influence of his pre-operative medication. While caring for him during this period she has an opportunity to study the patient as a person. Should there be any delay in the operating schedule, the doctor and the anesthetist are also able to observe the patient and make the desired change in orders for treatment and medication.

Post-operatively, the patient is returned to the P.A.R.R. in his own bed. The intravenous therapy continues, oxygen is given as necessary, and the patient's color, pulse, respiration, and blood pressure are observed constantly.

Let us look at the advantages of this plan. Mainly, they can be summed up under two headings—*safety* and *saving:* safety as it relates to the patient; saving as it applies to personnel, equipment, and time.

Relieved of all responsibilities other than giving immediate care to the patients going to and coming from the operating room, the experienced, well-trained staff of the recovery room can be depended upon to give the patient every attention. Requisites are at hand. No waiting for stimulants that have mysteriously disappeared from the ward just at the moment they are most needed! No more long delays at the elevator! Ward routine goes on without interruption and yesterday's operative patients receive the care which they require. Surely this is a safer and happier state of affairs than that which followed Mr. Smith's lobectomy.

Now, should anyone doubt the economy of a recovery room, let us suppose that immediately post-operatively seven patients, having had major operations, return to three of the hospital's surgical wards. These patients require constant attention, therefore seven nurses will be needed to remain with them until they can be safely left alone. This may take most of a day; certainly it will repre-



Post-anesthetic recovery room, Queen Mary Veterans' Hospital, Montreal.

sent many nurse-hours. Were these operatives returned to a ward especially prepared as a P.A.R.R. this wastage of nursing time would be avoided, since the task of supervising the immediate post-anesthetic care of patients is greatly simplified when they are placed in one rather than seven different rooms. Seldom would it be necessary to have more than two graduate nurses, with wide knowledge and experience in resuscitative measures, plus two or three well-trained assistants for a 10-bed recovery room.

Everyone will agree that less oxygen, suction apparatus, etc., is required to equip one room near the operating room than to meet the needs of several surgical wards scattered throughout the hospital. Those who are doubtful as to the saving this represents in dollars and cents, should remember that material assembled in the recovery room is not subjected to the hazards of being moved from place to place, down corridors, in and out of elevators. Also, they should not forget the fact that careful maintenance by the recovery room staff lengthens considerably the lifespan of expensive equipment.

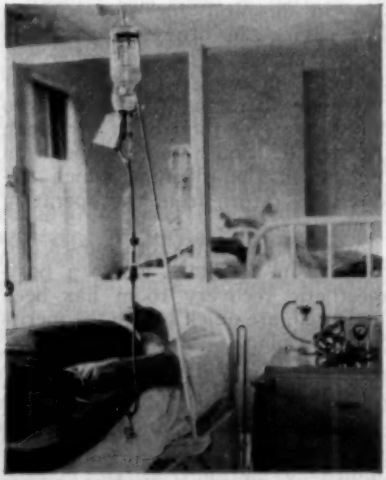
The time saved by centralizing staff and equipment benefits the patient, the doctor, and the nursing staff. Surgeons are spared the irritation of waiting for the patient to arrive in the theatre from the ward; the patient is already next door to the operating room. Minutes count when life is at stake. It goes without saying that a well-trained team, working calmly and with the necessary equipment, will save precious time and provide efficient resuscitation thus lowering the incidence of post-operative complication and prolonged stay in hospital for the patient. The saving in nurse-hours will ensure, among a host of other advantages, an enjoyable meal-hour for those like distracted Miss Jones, who doubtless never thought of her lunch the day Mr. Smith had his operation because of the dilemma which followed his return from the operating room.

Administrators, doctors, nurses, and patients in hospitals, where a post-anesthetic recovery room has been instituted, are quick to cite the merits of such a plan.

Dr. H. R. Griffith, in 1943, organized the first post-anesthetic recovery room in Montreal at the Homoeopathic Hospital. The success of his effort continues and even the responsibility of affording student nurses experience in this specialty is met.

They are rotated through it just as through any other clinical service.

At Queen Mary Veterans' Hospital, Montreal, the post-anesthetic recovery room has proven a real asset since its organization in 1946. The 10-bed suite, adjacent to the operating room, has been well furnished with all emergency equipment (see list below) and benefits by being merged with the sub-department of gas therapy. Therapeutic gas equipment is centralized near the recovery room, kept in excellent repair, and available to all parts of the hospital on a few moments' notice. These departments are regularly staffed by two graduate nurses, one senior gas-technician and his assistant, plus three nursing orderlies. One nurse is on duty 8:00 a.m.-4:00 p.m., the other 11:00 a.m.-7:00 p.m. Their allotted days off duty are taken over the week-end when only emergency operations are performed. The senior gas-technician is on duty 9:00 a.m.-5:00 p.m. and is relieved during his day off by his assistant. The nursing orderlies for the recovery room cover the three 8-hour shifts, day, evening, and night, and for days off they too are relieved by the assistant gas-technician, himself a trained nursing orderly. Should there be patients in the recovery room after 7:00 p.m., the evening float nurse and the recovery room orderly care for them. Likewise the night float nurse and the 11:00 p.m.-7:00 a.m. orderly are available if needed. If there is an emergency operation during the evening or night and the patient's post-operative condition is satisfactory, he may be returned to his ward where the recovery room orderly will attend him under the supervision of the ward nurse. Otherwise he is taken to the recovery room for the special attention he may require.



Using the individual irrigator stand.

Operative patients, accident and poisoning cases are treated in the recovery room at Queen Mary. Patients who have had a general anesthetic, a high special anesthetic, reconstructive surgery—for example, lengthy plastic and orthopedic work—in fact, all major operative cases, depending on the type of intervention and their physiological condition, are all given the benefit of the close attention of the staff of the recovery room where all resuscitative equipment is at hand.

Serious accident cases, belonging as they do to traumatic surgery, are brought directly to the recovery room on entering the hospital or in the event of a mishap occurring within the institution. Likewise, poisoning cases benefit by the immediate antidotal treatment of the well-trained staff.

The majority of patients remain in the recovery room only long enough to completely regain consciousness and a normal physiological state. Others, in view of the nature and extent of the surgery they have had—for example, intrathoracic and upper abdominal cases—require more complete care and a longer period of close supervision. Usually, however, the patients are back on their respective wards by 7:00 p.m. on the day of operation, having had the immediate post-operative transfusion, intravenous, and other resuscitative therapy which they may have required.

The records at Queen Mary Veterans' Hospital show that 50 per cent of the operative patients receive post-anesthetic care in the recovery room

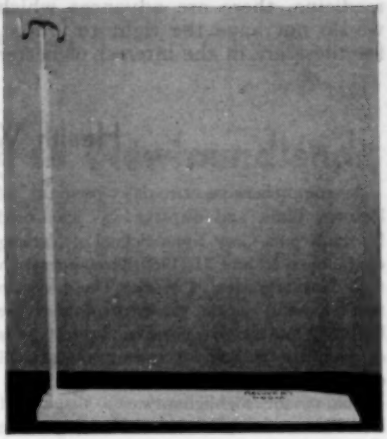
although their pre-operative medications are still being administered on the ward, a custom which is not ideal. Patients having had low spinal anesthetic, if their general condition permits, are returned directly from the operating theatre to their respective wards, since they are fully conscious. Statistics at this institution indicate that, following the inception of the recovery room, the operative mortality rate diminished, respiratory complications became less numerous, and poor-risk surgical cases were undertaken with greater success.

Drugs

Penicillin, neo-synephrine, prostigmine, vitamin K, amyl nitrate, metycaine, coramine, vitamin B, ascorbic acid (vit. C), caffeine sodium benzoate, solution of heparin, sodium pentothal, procaine, amp. of sterile water, ephedrine gr. ½, pitressin, insulin, adrenalin, A.P.C. & C. sodium luminal gr. II, methedrine 30 mg. antistine 1 gm., digoxin 5 mg., ephedrine gr. ¾, metrazol 1 gm., thiamin chloride, sulfanilamide crystals, sulfadiazine sol., nembutal gr. 7½ for I.V. use, aminophylline 25 gm., amp. of sterile normal saline, picrotoxin sol., sodium amytal 7/12 gr., soda bicarbonate, potassium permanganate, sterilized amp. of 50% glucose, nupercainal ointment, narcotics drawn from adjoining surgical ward.

Equipment

Three heavy duty suction pumps—Ingram & Bell; 5 airways anesthetic; 1 apparatus gas anesthetic—Heidbrink; 13 catheters; 1 flashlight; 1 forceps, thumb 6″; 2 forceps—Jones (similar); 1 forceps—Halstead Mosquito 5″; 2 forceps, tongue—Collins; 1 forceps—Magill; 1 forceps, tonsil—Seizing 9″; 1 gag, mouth—Doyan; 1 laryngoscope; 2 stethescopes–Douglas; 2 sphygmomanometer—Mercurial; 1 bulb irrigating syringe 4 oz.; 2 trays, instrument, 8″ x 4″ x 2″; 1 tray, catheter; 1 forceps, uterine serrated jaw; 1 hone carborundum; 1 safety razor; 12 arm-boards (padded and plastic-covered); 1 stomach tray (complete); 1 pneophore (artificial respirator); 4 sterile dressing containers; 1 tourniquet—Esmarch; 8 2-cc. syringes; 2 10-cc. syringes; 2 20-cc. syringes; 1 insulin syringe; hypo and intravenous needles; 3 small tourniquets; 2 plasma sets; 2 intravenous sets; 3 blood transfusion sets; 2 "Y" for blood transfusion; 1 cut-down set; 2 restraining jackets; 4 tanks of oxygen equipped with meter and mask (pressure); 1 tank of carbon dioxide and oxygen equipped with meter and mask; 3 intratracheal tubes; 2 thermometers; complete stock of intravenous fluids and plasma; 8 linen straps for restraining patient.



Close-up of irrigator stand.

Furniture

1 hospital bed, 1 desk, 9 bedside tables, 1 bed screen, 1 dressing carriage, 1 instrument cabinet (large), 6 irrigator stands (adjustable), 3 irrigator stands (portable), 1 instrument sterilizer, 1 medicine cupboard, 1 cupboard (large) for supplies, 7 kidney basins, 4 stands for raising foot of bed, linen and surgical supplies.

Conclusion: From the foregoing it will be noted that the ideal plan for applying the principle of centralizing hospital personnel and equipment to give safer care to patients requiring resuscitative care has been cited and that a concrete example of how a recovery room functions has been described. Many will appreciate the well-founded basis for the ideas regarding the post-anesthetic recovery room but will consider it too costly. Dr. Louis Lamoureux, adviser in anesthesia to the Director General, Treatment Services, Department of Veterans Affairs, has said: "Today, in

medicine, there are advances which we do not have the right to ignore, for these are in the interest of better treatment to our patients and to the evolution and future of medical science."

Health Week Project

A comprehensive two-day program of lectures, films, and displays was sponsored by the Regina Grey Nuns' School of Nursing on January 30 and 31, 1950, in co-operation with National Health Week. The program was planned to cover various aspects of the health education field. The project was directed by Sr. A. Levasseur, educational director of the school of nursing.

One of the highlights was a display of health education posters and literature. The display was made up of eight booths, one relating to each of the topics covered. Student nurses were on duty in the booths at each session. Many of the guests took advantage of the literature provided, which was obtained from several sources such as: the Health League of Canada, the Health Education Division of the Saskatchewan Department of Public Health, and from other agencies concerned with disease and accident prevention. Some of the posters were made by students of the school of nursing.

Some of the booths

Addresses were given at each of the sessions by guest speakers from the Department of Public Health or from the hospital interne staff. Instructors conducted groups of students in panel discussion and symposia.

Speakers and their topics were as follows: Dr. E. Hornstein, "A National Health Program"; Miss D. Hagar, nutritionist, Saskatchewan Department of Public Health, "Some Aspects of Modern Nutrition"; Dr. O. G. Burns, "The Expectant Father"; Dr. G. Bray, "The Common Cold"; Dr. D. Thompson, "Child's Health"; Dr. R. T. Hosie, "Prevention of Diseases"; Dr. W. MacDiarmid, "The Importance of Preventing Accidents"; Miss O. H. Anderson, director of health education, Saskatchewan Department of Public Health, "The Need of Health Education."

A panel group

Discussion participants included: Miss M. Howell, health nurse; Miss J. Butterfield. dietitian; Miss D. Martin, assistant supervisor, obstetrical department; Miss F. Hummason, basic science instructor; Mrs. N. Street, science instructor. Students from all classes took part. A film pertaining to the topic under discussion was shown at each session.

Others who took part were: Miss M. Crawford, who made the opening remarks at each session; Miss B. Fay of the pediatrics department, who introduced the speaker on "Child's Health"; Mrs. A. O'Shaughnessy, medical clinical instructor, who introduced the speaker on prevention of diseases. Miss Anderson expressed the interest of her department in such projects and commended everyone for their interest and effort.

Each session was well attended. Students from collegiates in the city, Sisters, internes, graduate nursing staff, employees of the hospital, and students of the school of nursing were among those present.

A good diagnostician is always a pessimist: he looks for the worst.

Public Health Nursing

Public Health Nursing in Newfoundland

ELIZABETH R. SUMMERS

Average reading time — 9 min. 12 sec.

WE WERE very pleased indeed to receive an invitation to write about public health nursing in Newfoundland for *The Canadian Nurse* and we are glad of the opportunity of letting the rest of Canada know what we are doing here in that field.

In comparison with the other provinces, public health nursing in Newfoundland may be said to be in its infancy. None the less, we feel that within the past twelve years we have progressed so that now we can say that we have an organization to which we may point with pride. At the same time, we hasten to add that we are well aware of our many deficiencies and are constantly endeavoring to augment and improve the service.

Actually, we have too big a job for the available nurses. In this, of course, we are not unlike many of our sister provinces. However, our biggest problem, transportation, places us in a different category.

The island of Newfoundland is mostly settled along the coast-line which, as can be readily seen from any map of the Island, is heavily indented with numerous bays of varying sizes. Many of these settlements are cut off from one another except by sea, which is not always favorable for travelling by small boats. Thus it may be understood that while a given area serviced by a district nurse may look comparatively small, at the best of times she has difficulty covering it with satisfaction. Then, too, many places are without the services of a nurse at all.

Miss Summers is educational director with the Department of Health, St. John's, Newfoundland.

Perhaps a short account of the history of public health nursing here would be of interest at this point.

HISTORY

Up to 1920 there was no organized nursing in Newfoundland outside of the hospitals and those who did private nursing. At this time district nursing began under the auspices of "Nonia" (Newfoundland Outport Nursing and Industrial Association) which started with two nurses. In 1934, when the government took over the Nonia Nursing Centres, there were six or seven of them. New outport centres were then set up and a city service was started in St. John's mainly to provide care for the poor and to improve maternal and infant health.

In 1937 a Division of Public Health Nursing was started under the direction of Miss Syretha Squires (now Mrs. Scott Milley). These services were amalgamated in 1940 when it was considered that much of the work being done was overlapping. Since then the nursing service has expanded at a great rate. At the present time a considerable proportion of the population has available care both curative and preventive, through the Department of Health.

There are at present:

1. Fourteen cottage hospitals.
2. Twenty nursing districts (11 vacant).
3. Six nursing stations.
4. St. John's Unit (4 districts).

The cottage hospitals vary in bed capacity from 12-30 beds, depending on the population of the area served. There are two converted military hospitals—one each at Gander and

Botwood with a 50-bed capacity. Nursing duties are divided between two or three nurses with ward aides for assistance.

Nursing stations are staffed by a district nurse, a ward aide, and a cook. They are set up with two to four beds for emergency care, such as when a district nurse has a difficult confinement to attend or for a patient who might need care while waiting for admission to hospital.

The district nurse carries out a service consisting of a generalized nursing program, which includes more than is usually required of a nurse due to there being in most cases no doctor available. Advice and hospitalization are sought from the nearest hospital or doctor if there is one within reasonable distance. Otherwise, the Department of Health is notified and, on occasion, a plane is sent to her assistance.

St. John's district also carries out a generalized nursing service including:

1. Morbidity service—communicable and non-communicable diseases.
2. Maternal and infant care.
3. General and specialized clinics.
4. Preschool and school health.
5. Health supervision and education for various groups.
6. Tuberculosis dispensary (with mobile x-ray unit).

One of our problems is lack of professional education. Although some of our nurses have taken public health courses, and there are others doing so at the present time, the majority must take up their duties after an orientation and staff training program of six months' duration at the St. John's headquarters. This must often be shortened due to the pressing need for nurses.

In spite of many difficulties, the public health picture shows marked improvement during recent years. The nursing service rightly may take credit for some of this. The infant death rate has been reduced although it is far from being low. The incidence of diphtheria, typhoid, and whooping cough is considerably less. While the known cases of tuberculosis still reveal infection in a comparatively high percentage of the population, much has been done in the field of case-finding and subsequent hospitalization of those whose disease indicates the best chance of being arrested. Home visiting of tuberculosis patients and their contacts constitutes a vital part of our program.

Public health nursing presents a real challenge such as perhaps is found in no other province. For a nurse who is enthusiastic and who is prepared for any type of emergency as well as for the routine nursing problems, nursing in a cottage hospital or in a district provides satisfaction without compare.

While it is well known that diagnosis is outside the field of a nurse's duties, there are times and places where circumstances in Newfoundland demand of the district nurse at least tentative diagnosis and limited treatment for a variety of diseases. Though for emergencies and difficult cases assistance can be obtained, decision must also be made in many a situation where she would give anything to have a doctor close at hand.

In the outports, home confinements are the rule, the nurse and the resident midwife being always on call. The majority of small settlements have the services of a midwife who, if suitable, may undergo two months' training at government expense at a hospital in St. John's. She is then granted a licence to practise in a given area. No unlicensed midwife may practise in the same area. These midwives are under the supervision of the district nurse and must refer difficult cases to her.

Nursing in a cottage hospital means that the nurse is one of a small but vital unit, whose concern is the health of a designated community. This may be extensive and cover miles of coastline. While these hospitals are administered by the Department of Health, which at all times has its eye on preventive measures, it can generally be stated, however, that their main concern is curative rather than preventive. This is by no means through inclination; rather it de-

velops directly from the pressure of emergency and general medical and surgical work to be done.

The cottage hospitals have a resident doctor, a nurse-in-charge, and one or two staff nurses, depending on their bed capacity. The nurse-in-charge has to take over the responsibilities of everything—administering anesthetics, training ward aides, ordering supplies, housekeeping, and general supervision of the hospital. She is also on call for surgery and other emergencies alternating with the other nurses.

We have no unofficial or private organization in Newfoundland doing visiting nursing. As a consequence, our preventive program must take second place to bedside nursing in the home. The wonder is that some of the nurses find time for anything else.

We have a Child Welfare Association in St. John's which is doing invaluable work in infant health and welfare. They carry the whole preschool immunization program, as well, for the Department of Health and conduct general clinics with a medical officer of health. They have two Department of Health nurses on their staff. The Red Cross conducts well baby clinics at several centres. There is also one cottage hospital at Gander which has its well baby clinic.

Public health nursing is administered by the director of the Departmental Nursing Service, within the Department of Health, assisted by the supervisor of the St. John's staff and the field supervisor, who visits as many cottage hospitals and districts in a year as transportation permits. Staff education is carried out by the educational director. Health education on all levels is also part of the nursing service program.

In Newfoundland we have our own peculiar problems which we must work out accordingly, but we try to follow closely the progress of our more experienced sister organizations and have much to thank the Victorian Order of Nurses for Canada for in that our organization was patterned along their lines.

Nursing Sisters' Association

A Theatre Night was sponsored by the *Ottawa Unit* in March at the Little Theatre. Mrs. P. T. Sharpe was the convener for this project, assisted by Mmes P. J. Philpott, E. S. Perkin, and Miss G. Clark. The Ottawa Drama League Workshop presented "Payment Deferred" to a capacity audience. This performance greatly assisted the Unit in raising money for the Benevolent Fund.

Trafalgar House was the scene of a Fireside Hour when the executive of the unit entertained following the evening National Nurses' Vesper Service at St. John's Anglican Church held in May. The president, Evelyn Pepper, welcomed the guests who represented all branches of civilian nursing. Light refreshments were served, with J. Attwood as convener. A peppy sing-song concluded a successful evening.

Nurses Awarded Medals

Two nurses, who fought a diphtheria epidemic among Indians in northern British Columbia last winter, were recently presented with gold medals by two B.C. Cabinet ministers. Aileen Bond, of Kelowna, B.C., a graduate of St. Paul's Hospital, Vancouver, and Amy Wilson, of Calgary, Alta., a graduate of Calgary General Hospital, were honored for their part in fighting a diphtheria epidemic which raged through an Indian reservation in isolated Halway Valley.

The medals, centred by a diamond, were accompanied by parchments which read: "For outstanding courage—above and beyond the call of duty—an example of the co-operation between federal and provincial health services. A magnificent chapter in the development of public health nursing in Canada." (See News Notes, May issue, p. 407.)

Prevalence of heart disease rises with advancing age. Between ages 40 and 80 the rate about doubles every 10 years.

Aux Infirmières Canadiennes-Françaises

Le Travail Médico-Social

JACQUELINE GAGNON, B.Sc.H., M.S.S.

Average reading time — 15 min. 36 sec.

LA PROFESSION d'infirmière, comme d'ailleurs toutes les autres professions, a subi des modifications profondes depuis les 25 dernières années. Lorsqu'on se reporte, à ce que nous pourrions appeler l'enfance du nursing, on constate que le standard professionnel était loin d'être ce qu'il est aujourd'hui. Sans vouloir déprécier la valeur des pionnières dont la foi en l'avenir et le travail personnel furent grands, il nous est bien permis de constater que les exigences actuelles pour l'admission au cours de garde-malade et que les programmes d'études se sont haussés graduellement jusqu'à donner à l'infirmière graduée le statut d'une professionnelle authentique. Il y a lieu, me semble-t-il, d'applaudir à ces progrès, comme aussi de féliciter toutes celles qui ont le courage de s'astreindre à ces disciplines qui demandent tant de ténacité et d'abnégation.

Si excellente que soit la profession de garde-malade, il est incontestable que les progrès modernes et les obligations de la vie actuelle nécessitent une compétence sans cesse accrue de la part de celles qui veulent suivre véritablement le rhythme des transformations qui bouleversent tous les milieux. C'est pourquoi, aux études régulières de la garde-malade, viennent s'ajouter, pour celles qui ont de l'enthousiasme et de l'idéal, des études complémentaires qui permettent d'accéder à des titres universitaires, aussi bien dans le domaine médical que dans le domaine social.

On se plaint, non sans raison, de la pénurie d'infirmières, mais quel n'est pas le besoin de gardes-malades spécialisées en service social, en hygiène, en psychiatrie, etc. Nous espérons aider au recrutement pour l'une ou l'autre de ces spécialités en décrivant très brièvement les activités d'une infirmière dûment qualifiée et son rôle dans un service médico-social. Afin de mieux situer le problème, définissons tout d'abord les termes *service médico-social* et *travail d'équipe*.

Le *service médico-social* est un organisme destiné à aider le patient à résoudre les problèmes qui sont la conséquence immédiate de son état de malade, qu'il soit à domicile ou hospitalisé. La maladie, en effet, crée un état pathologique qui empêche celui qui en est la victime de vaquer à ses occupations ordinaires, familiales, sociales, ou professionnelles. Ce sera donc le rôle du service médico-social de lui fournir les moyens, les conseils, et l'assistance qui lui permettront de s'adapter à cet état passager, mais difficile et pénible.

Par *travail d'équipe*, nous entendons l'effort soutenu d'un groupe de personnes qui conjuguent leurs connaissances, leur conscience professionnelle, et leurs techniques pour la poursuite d'un but déterminé.

La réhabilitation totale d'un malade est une tâche des plus complexes—l'infirmière spécialisée en service social ne pourra, il va s'en dire, l'accomplir seule. Son rôle, d'ailleurs, n'est-il pas de seconder dans toute la mesure du possible les médecins traitants? D'autre part, sa mission est également de préparer le patient à accepter sa condition et les traitements destinés à l'améliorer. Cette mission,

Mlle Gagnon est attachée au centre anti-cancéreux de l'Hôtel-Dieu de Québec.

on le comprendra, ne peut être menée à bien que si toutes les personnes du service acceptent de mettre en commun leur science et leur dévouement dans un véritable travail d'équipe pour le plus grand bien du malade. Les activités d'une clinique anti-cancéreuse nous serviront à mieux illustrer le véritable travail d'équipe.

L'Infirmière Assistante Sociale

Le rôle de l'infirmière dans un service médico-social s'accomplit en deux étapes: (a) le premier contact; (b) le travail médico-social proprement dit.

Premier Contact

Dans une clinique anti-cancéreuse, l'infirmière assistante sociale doit servir d'intermédiaire entre le médecin traitant et le patient. Son action s'exerce de façon toute particulière au bénéfice du malade. Dès la première entrevue elle devra s'enquérir de son histoire médicale. Elle s'intéressera ensuite à son histoire sociale, à ses problèmes familiaux, financiers, psychologiques, puisque l'ensemble de ces problèmes est inséparable de l'état pathologique. On a signalé, et avec raison, l'influence du moral sur le physique. On comprendra, dès lors, quels services inappréciables peut rendre une infirmière spécialisée en service social. Ses connaissances psychologiques et ses techniques de travail social lui permettront de mieux disposer le patient à accepter les services du médecin et à en tirer le maximum de profit.

L'histoire médicale et sociale du malade étant ainsi préparée, il appartient à l'infirmière d'en faire part au médecin qui le traite. Ces renseignements préliminaires permettront à celui-ci de se faire déjà une opinion précise sur le patient et sur l'attitude qu'il convient d'adopter à son égard. Le médecin fera alors son examen, il posera son diagnostic et recommandera le traitement le plus adéquat. Si l'hospitalisation est jugée nécessaire, l'infirmière devra appuyer cette décision, la faire accepter, en démontrant au malade que le séjour à l'hôpital favorisera des examens plus satisfaisants et des soins plus efficaces.

Dans une clinique anti-cancéreuse, la responsabilité du diagnostic et du traitement incombe à plusieurs personnes: médecin, chirurgien, radiologiste, anatomopathologiste, gynécologiste, radio-thérapeute, auxquels seront adjoints des représentants des différents services. Lorsque chacun de ces spécialistes a vu le patient, il est de la plus haute importance qu'une conférence de cas les réunisse avec l'infirmière assistante sociale afin d'aviser à la ligne de conduite qui doit être suivie pour le traitement. Cette mise en commun des constatations individuelles dans le domaine médical, aussi bien que sur le plan social et psychologique, permettra d'assurer l'unité d'action et une collaboration plus efficace pour le plus grand bien du malade. De plus, cette étude globale des différents aspects d'un cas particulier permettra à l'infirmière assistante sociale de mieux comprendre le rôle qu'elle doit jouer et de seconder plus efficacement tous les spécialistes traitants.

Travail Médico-Social Proprement Dit

Après le premier contact avec le personnel de la clinique anti-cancéreuse, le patient est fixé sur son cas, à savoir s'il doit être hospitalisé où s'il peut retourner dans sa famille. Nous considérerons donc successivement l'une et l'autre alternative pour bien déterminer quel doit être le rôle de l'assistance sociale-médicale dans chacune.

Patient Hospitalisé

L'hospitalisation étant acceptée par le patient, grâce au travail préliminaire de l'infirmière, il y a lieu de distinguer entre le patient convenablement fortuné et celui qui n'a aucune ressource. Dans le premier cas, il semble que l'hospitalisation paraîtra moins pénible, en raison des services multiples que la fortune permet de se procurer. Dans le second, l'assistante sociale-médicale aura parfois beaucoup à faire auprès de ces malades pauvres, obligés d'accepter les services hospitaliers dans une salle commune. Le séjour à l'hôpital offre cependant aux uns et aux autres qui souffrent des mêmes misères physiques et souvent morales, d'importants avantages en particulier, celui de recevoir régulièrement la visite de l'infirmière assistante sociale qui peut exercer à leur endroit un apostolat fructueux tant au point de vue social qu'au point de vue psycholo-

gique et religieux. Pour les malades hospitalisés, le rôle de l'assistante se borne à ce que nous venons de dire, puisque tout le personnel médical de l'hôpital demeure continuellement au service du patient.

Lorsque le traitement a donné des résultats qui permettent le retour dans la famille, l'infirmière doit se préoccuper d'assurer au malade un minimum de bien-être et les médicaments indispensables à son état. Elle le disposera aussi à rester en contact avec la clinique, soit par les visites qu'elle pourra lui faire, soit par les examens périodiques, soit par la correspondance.

Patient Externe

Dans une clinique anti-cancéreuse, le patient externe est celui qui vient à l'hôpital pour des traitements définis. Nous pourrions également ranger dans cette catégorie tous ces malades qui, après un séjour à l'hôpital ou une série de traitements, demeurent sous l'observation du médecin et de l'infirmière visiteuse.

Dans ce cas le rôle de l'assistante sociale-médicale consiste à veiller à ce que le malade demeure en contact périodique avec la clinique anti-cancéreuse. Lorsqu'il s'agit de patients dont les moyens pécuniaires sont à peu près nuls, l'infirmière doit leur assurer tout ce que requiert leur état, tant au point de vue médical qu'au point de vue social et religieux.

Conclusions

Ce bref aperçu illustrera le véritable travail d'équipe dans un service médico-social et le rôle que joue l'infirmière assistante sociale; le développement personnel de chacun des membres qui contribue au travail, l'acquisition des techniques médico-sociales, l'utilisation de tous les moyens pour la poursuite et la réalisation de la même fin. Pour sa part, l'infirmière adhère totalement au travail d'équipe par son assistance au médecin, sa compréhension vis-à-vis du malade, l'interprétation de son cas —en un mot, sa collaboration parce que là, justement, elle met en oeuvre les ressources dont l'institution ou la société dispose pour permettre au patient de traiter sa maladie convenablement.

De plus, nous trouvons les avantages d'une spécialisation comme complément au cours de garde-malade. Sans vouloir sous-estimer la formation donnée par nos écoles d'infirmières, nous croyons de notre devoir d'encourager nos graduées à poursuivre leurs études dans une voie qui semble vraiment répondre à leurs aspirations personnelles. En effet, dans le domaine social, pour n'en mentionner qu'un, elles trouveront un champ d'activités illimitées et des possibilités d'action qui leur procureront des joies profondes et, ce qui ne gâte rien, des rémunérations propres à répondre aux exigences d'une vie vraiment professionnelle.

Manitoba

The following are recent staff changes in the Public Health Nursing Service, Manitoba Department of Health and Public Welfare:

Appointments: *A. Cymbalist* (St. Boniface Hosp.), *Audrey Haverstick*, *Lois Joyce* (Winnipeg Gen. Hosp.) to Dauphin; *I. M. Moore* (Grace Hosp.) to Fisher Branch nursing station; *J. Lazaruk* (Winnipeg Gen. Hosp.) to Neepawa; *E. Brenner* (Grace Hosp. and University of Man. public health course) to Selkirk.

Transfers: *Lillian Blair* from Flin Flon to Brandon; *E. Crookshanks* from Neepawa to Stonewall; *Eleanor Henderson* from Selkirk to Dauphin; *Ruby Jorey* from Fisher Branch nursing station to St. Boniface; *L. Rasmussen* from Dauphin to Selkirk; *Janet Smith* from Red River health unit to northern health unit, Flin Flon; *A. Stadnyk* from St. James to Transcona; *Jessie Williamson* from Dauphin to Red River health unit.

Resignations: *Anne (Ancion) Boux* from Selkirk; *S. Liffman* from Virden to take public health course at University of Man.

On February 14, *Elizabeth Russell* completed 34 years service as director of the Manitoba public health nurses. *A. K. Smith*, educational nurse for the Cancer Research Institute, has returned from Columbia University where she received her B.S.

Lyle Creelman *Writes . . .*

Average reading time — 4 min. 24 sec.

WHEN this reaches print it will have been nearly one year since I left Canada to join the Secretariat of the World Health Organization at Headquarters in Geneva. It is high time that I began to tell you a little bit about our nursing activities, about life in Switzerland, and perhaps something of nursing in other countries as we learn of it through personal visits or in reports from WHO nurses.

The Nursing Section of WHO is very new—as a matter of fact it really isn't officially a section until approved by the Assembly which meets in May. There are two of us at Headquarters—Miss Olive Baggallay, formerly secretary of the Florence Nightingale International Foundation, who is the Chief of the Section, and myself.

To date we have 18 nurses in "the field" and, as an orientation to the WHO nursing program, you might like to know briefly where they are and what they are doing. Six of them are public health nurses assigned to malaria teams in India, Pakistan, and Thailand. The nurse on the malaria team not only assists in the initial survey which must be made but, as the program develops, she concentrates on the development of a public health nursing service, particularly for the mothers and children. These nurses have had some very thrilling experiences about which I shall tell you at another time.

A public health nurse with special preparation in pediatrics is assigned to the College of Nursing in New Delhi and is helping to improve the clinical preparation in this field. She will shortly be joined by a second public health nurse who will assist in the organization of the nursing aspects of a field training area just outside New Delhi at Najafgarh. Already at Seoul in South Korea, Miss Visscher, a Dutch nurse who recently obtained her diploma in public health nursing from McGill School for Graduate Nurses, is helping to organize a similar training area for nurses.

On the Island of Borneo, almost on the Equator, four WHO nurses arrived at the end of January. As they all went from the winter climate of Europe and England, the physical adjustment has not been an easy one. Two who are assisting in the development of the midwifery program and the pediatric service in the Kuching Hospital, Sarawak, live in a bungalow on the compound, along with their servants, a Chinese man and wife and their six children! The others of this group are at Brunei and are engaged in a more generalized type of public health nursing. Their descriptions of making home visits to the River Kampongs will also be of interest.

Two public health nurses are assigned to venereal disease teams—one in the beautiful mountain area of Simla, India, and the other to a centre in the flat fertile area of Lower Egypt. Three nurses are doing special work in tuberculosis—two in China and the third in one of the largest sanatoria in the world (2,000 beds) just outside Athens. And, finally, Miss Dallaire from Montreal is in Haiti where WHO is cooperating with UNESCO in a fundamental education project.

You will notice from the geographical distribution that there is a concentration in the South East Asia Region. This is partly because of a great need which the countries recognized and for which they made early requests for assistance and partly because many of these projects are financially supported by UNICEF.

Perhaps you are not aware that for the administration of the programs of WHO, the world is divided into six regions: the European, African, Eastern Mediterranean, South East Asia, Western Pacific, and the Americas. To date there are only three regional offices—Alexandria, New Delhi, and Washington, where the office of the PASB (Pan American Sanitary

Bureau) serves also as the regional headquarters for WHO in the Americas. Canada, of course, is a part of this latter region. We will have a Nursing Adviser at each regional office as they are organized and as we can find suitably qualified nurses who are not already committed to important positions.

The space allotted by the editor is more than full. Very soon I would like to tell you about my first field trip which included an extensive visit in Egypt and a hurried trip to Persia and Lebanon, all most fascinating countries and with more problems to solve in nursing than you have ever dreamed of in Canada.

The Nurse and the Law

CARL LEDOUX

THIS IS THE FIRST opportunity I have had to address your profession on a topic of mutual interest. Our respective callings have a great deal in common, though this may not be apparent to the casual observer. We are both in the public service. While you minister to man's health, we look after his safety.

The health of the community is largely in your hands and, in the hour of pain and sickness, it is your capable skill which brings care and solace to the unfortunate, fanning the feeble ember of life back to the full fire and vigor of health and happiness. Your profession has no greater admirers than the men of my calling. We have seen you work under the most trying conditions without regard to self. We know that the nurse will go far beyond the call of duty in helping humanity and implementing your honored pledge. Your work comes to our notice more forcefully in small communities where epidemic and disaster are met with courage and efficiency, regardless of privation and long hours of duty.

Here is where the community of purpose between us becomes more apparent. It is our duty to bring help to the sick and the maimed, while you restore them to a state of well-being. Frequently, tragedy is averted only by the unstinted and complete cooperation of nurse and policeman. The lost trapper, with gangrene creeping through frozen feet; the child, victim of an overturned washtub of boiling water; the crew of a wrecked freight train; the broken victim of a hit-and-run accident; the entombed miners of a major pit disaster, and many others testify to the co-ordination and integrated effort of our two professions.

I trust that my remarks will be of some value to you and that they will serve to stimulate even greater cooperation between us, by an explanation of certain phases of our work in which you can be of invaluable assistance.

Perhaps it might be as well to discuss the law first. In antiquity, and we can trace law back to the days of King Hamurapi of Babylonia over two thousand years before the birth of our Lord, the wish of the ruler was the sole law of the land. He had complete power of life and death over his subjects and dictated according to his whim or fancy.

The punishments inflicted for disobedience were terrible. They involved torture and maiming, as well as the forfeiture of life for small offences. The law, therefore, depended upon the current ruler's temperament and disposition. Hence we hear through legend and history of some king being "good," while another is

Sub-Inspector Ledoux has been associated with the Criminal Investigation Branch of the British Columbia Provincial Police for a number of years and is at present in charge of the Provincial Police Training Depot.

termed "bad," according to the laws he created. The lowly individual not born to the purple had no rights at all. Under our present system, the law (at least in democratic countries) is the will of the people, expressed through their elected representatives and is enacted for the peace, happiness, and good government of the community.

Many people say we are overgoverned, that we have too many laws, and that they are an impediment to our progress. Let me put it this way. If a man lived on a desert island alone, he would have no need for law. His every wish would be his own law of the moment. But let someone else come to the island to live and the picture immediately changes. These two people must have some rules to govern themselves so that each may enjoy his full rights and liberty without fear of infringement by the other. They must arrange a system of penalties for non-compliance with the rules. As the community grows, the need for rules or law becomes greater. Interests differ by reason of occupation, temperament, and habit. Therefore the greater the size of the community, the greater the number of laws that are required for its proper governance.

Again, we have inventive and industrial development to contend with. Let us take the automobile. A hundred years or so ago, there were laws governing teamsters, drivers, and waggoners. Racing horses on the highways was prohibited. The laws for the governance of traffic were few and easily complied with. Now, however, with the advent of the motor car, there has been a considerable increase in legislation to meet new problems. The law appears to have increased in proportion to the number of vehicles on the road. We have a motor vehicle act in every province in Canada. There are special laws for motor carriers. The criminal code has a number of sections respecting motor vehicles, and there are a host of ancillary statutes such as the Gasoline Tax Act and so on. Even with all this legislation, we have the unhappy spectacle of hundreds of lives being lost in Canada every year through automobile accidents.

As the complexity of life increases, so does the necessity for additional rules or law. If you think we have too many laws, think of the dictatorships, where law governs man's every action, even to dictating what he may think. Law of this type ceases to be justice, but becomes plain bondage.

The law provides safeguards for rich and poor alike, rendering both justice and protection. Without the balance wheel of the law, the community would disintegrate, licence would be rife, and the only protection would lie in the use of force—a retrogression to the animal state.

Now, the leaders of a community are the ones who, by example and observance of the law, set the moral "tone" for their fellows. If they assist the processes of the law, then justice will prevail, but if they are indifferent justice will have received a severe set-back.

I unequivocally place nurses among the leaders of the community, both by virtue of their work and their high moral standards. Thus it behooves the nursing profession to lend every possible assistance to the cause of justice for the common good. The nurse has a very high responsibility both to patient and doctor but this responsibility does not stop with the physical condition of the patient. It also extends to his spiritual and temporal rights when they must be safeguarded by others through his incapacity. The victim of a cowardly attack has the right to demand justice. It is not sufficient to save his or her life, but the person guilty of perpetrating this crime must be brought to trial and punished for violating the rights of his victim. The nurse can greatly aid this process and, unless she fully co-operates, she will only have partly fulfilled her pledge to her professional standards and to the community which holds her in such high esteem.

Let us discuss the ways and means in which nurses may help. Frequently, the victim of a hit-and-run automobile accident or of a homicidal attack

is brought to the hospital directly from the scene of the crime. It becomes the nurse's duty to prepare the victim for medical attention. This is her first contact with the patient and naturally her principal thought is for the preservation of life. However, there are a number of factors in which we are vitally interested from the moment the patient enters the hospital. Take the clothing, for example. A patient's clothing is often in very bad condition, fouled with blood and mud, torn and useless. We have many instances of clothes in such condition being thrown away or burned in the furnace to get rid of them.

From our point of view this is very poor policy and may result in the escape of the guilty person from the just consequences of his act. *Clothing, regardless of its condition, should be preserved until the investigation is completed.* In a hit-and-run case, there is a possibility that a button ripped from a coat may be found in the radiator grill of the offending vehicle, or perhaps a few shreds of material may be wedged in the bumper, or there may be a few broken flecks of paint embedded in the victim's clothing, forced into the fabric at the time of impact, and so on. The garments would be, therefore, a prime necessity to the prosecution.

(*To be continued next month*)

Expert Committee on Nursing

Nurses from a variety of countries met under WHO auspices to recommend adequate training programs for nurses and measures to improve their economic and social status.

Around the table (*left to right*) may be seen: ELIZABETH BRACKETT, Nursing Adviser, Rockefeller Foundation, Paris; MLLE M. L. DAVID, Assistant Director, School of Nursing, Ecole Professionnelle d'Assistance aux Malades, France; the interpreter; MISS T. K. ADRANVALA, Chief Nursing Superintendent, Directorate General of Health Services, India; YVONNE HENTSCH, Director, Nursing and Social Service Bureau, League of Red Cross Societies, Geneva; LYLE CREELMAN, Nursing Section, WHO; VENNY SNELLMAN (vice-chairman), Inspector of Nursing Education, Finland; MARY I. LAMBIE (chairman), Ex-Director, Division of Nursing, New Zealand; OLIVE BAGGALLAY, Nursing Section, WHO; DR. MILLER; MISS MURRAY, secretary (in corner); MISS F. N. UDELL, Chief Nursing Officer, British Colonial Office; DAISY BRIDGES, Executive Secretary, International Council of Nurses; MISS G. PEAKE, Director, University School of Nursing, Chile; MRS. A. S. W. CHAGAS, Chief, Nursing Section, Pan American Sanitary Bureau, Washington.

Trends in Nursing

Average reading time — 6 min. 24 sec.

General Interest Sessions

THE PLANNING COMMITTEE met on January 30, 1950, discussed plans and agreed upon the following exhibits and demonstrations to be presented at the C.N.A. biennial meeting in June:

(1) Neurological nursing; (2) Body mechanics in nursing; (3) Demonstration of special equipment for industrial nursing; (4) New type of V.O.N. bag; (5) Central supply room; (6) Premature nursery equipment; (7) Special recovery room—chest surgery; (8) Cardiac surgery; preoperative and post-operative care of "The Tetralogy of Fallot"; (9) Educational program as carried out in the Division of Tuberculosis Control; (10) Intravenous team; (11) *a.* Audiometer testing, *b.* Telebinocular, *c.* Wood's Light in diagnosis of ringworm; (12) Budgetting in nutrition; (13) Use of Cantor tube in intestinal obstruction; (14) "The Team" caring for the patient, in and out of hospital (emphasis on the social worker); (15) Equipment used in homes for treatment of arthritis; (16) *a.* Treatment of anterior poliomyelitis, *b.* Burn therapy; (17) Diagnosis and treatment of cancer; (18) Attractive favors, place cards, etc.; (19) The oscillating bed; (20) The showing of films; (21) The artificial kidney; (22) Rehabilitation; (23) Pediatric surgical nursing; (24) Pediatric medical nursing; (25) The Foster bed; (26) The recovery room; (27) Psychiatric nursing —A series of photographs will be taken for the purpose of illustrating psychiatric nursing from admission to discharge. Equipment will be set up for electric shock and electronarcosis and nurses will be selected to demonstrate and explain.

The Needs of the Patient

The Ward and Departmental Sisters' Section reported the setting up of a sub-committee to consider hospital nursing duties in terms of patients' needs. The Section felt that, although the job analysis being undertaken by the Nuffield Provincial Hospitals Trust into the task of a nurse would yield much interesting information on what the nurse actually does in hospital, something complementary was needed, something which would give a picture of *optimum* nursing conditions—an analysis of the ideal care different types of patients should have from the time of admission to discharge and rehabilitation. Such an analysis it is felt would be valuable because it is complementary to the purely factual survey on which the Trust is engaged.—*excerpt from* "What The Royal College of Nursing is Doing" (Feb. 16, 1950)

The Experts Report

In this press release the World Health Organization reports on recommendations made by an Expert Committee of WHO which met in Geneva in February, 1950.

In the committee's opinion, efforts to improve the acute shortage of health personnel in the nursing field require three simultaneous and related approaches:

(a) The securing of candidates for training of all types; (b) the promotion of the most effective use of various categories of nursing personnel; (c) provision of expanded educational facilities.

The committee recommends: (1) That studies be made on the national and international levels of factors preventing recruitment (competition of more attractive professions, customs, and traditions, lack of sufficient type of training). (2) That, as the above factors are directly related to the social and economic status of women and to psychological attitudes of related health personnel and other professional groups, these studies be conducted by a staff, including psychologists and sociologists. (3) *a.* That a joint WHO/ILO pilot study be undertaken

on working conditions of nursing personnel, including hours, salaries, health conditions, and other personnel policies; *b*. That this study include the qualifications of nursing personnel, adequacy of supervision, standards of service, and problems of recruitment; *c*. That the non-governmental International Council of Nurses be requested to assist with this pilot project. (4) That modern health work, based on the new approaches toward physical, social, and mental environment, requires a basic change in education procedures for nurses: (a) in regions with highly organized programs of nurse training (reorientation to give trainee insight into psychological problems of nursing); (b) in regions in which nursing education is in early stages of development.

The committee formulated a series of recommendations setting minimum requirements at all levels for nursing personnel. WHO's role, the committee stated, should be:

(1) To provide governments with information on various aspects of nursing, including the available training programs throughout the world. (2) To foster educational opportunities through fellowships, international seminars on nursing problems, and promote a wide distribution of nursing literature everywhere.

The Expert Committee also asked WHO to undertake fundamental research using anthropological and sociological methods to determine the real health need of people in societies at various stages of development.—*WHO Press Release* No. 36 (Mar.2.50)

I.L.O. Interested

The International Labor Organization representative to the second World Health Assembly made this statement:

That I.L.O. has particular interest in two aspects of world health: first, in the health of the industrial worker and the development of programs in industrial hygiene and, second, *in the working conditions under which personnel in health programs are employed*. The I.L.O. is especially concerned about the working conditions of nurses throughout the world and it expects to give attention to their improvement wherever possible.—*American Journal of Nursing* (Dec. 1949, p. 766)

Revised Booklet

The Canadian Nurses' Association is very proud to present to you the revised edition of "What You Want to Know about Nursing." You have been waiting for it for a long time but we are sure you will agree that it was worth waiting for. We are pleased to tell you that this lovely booklet is the work of the Information Services Division, Department of National Health and Welfare, by authority of the Minister, the Hon. Paul Martin. You will be proud to place this book in school libraries and in the hands of high school students. The format is attractive, the print good, the illustrations of real people in actual situations are excellent, and the subject matter authoritative. The message from Dr. G. D. W. Cameron, Deputy Minister of National Health, lends the book prestige and should appeal to the idealistic young girl. Copies have been mailed from the Department of National Health and Welfare to all provincial nurses' associations. Additional copies may be secured, free of charge, through your Provincial Department of Health. We hope you will like the way the story has been presented and will find the book a help to you in interpreting nursing to the potential student.

The Minister of Immigration in Australia is reported to have asked the newspapers there to stop using the term "D.P." in relation to the new-comers. "The newspapers applauded the Minister's plea and have cooperated generously in avoiding use of the term."

While no such governmental request has been made in Canada, we would do well to follow Australia's example.

Orientation et Tendances en Nursing

Y a-t-il suffisamment d'infirmières au Canada pour répondre aux besoins de la population?

Les statistiques que nous avons sur le nombre d'infirmières, pouvant répondre aux demandes toujours croissantes de la population, datent de 1948. Malheureusement, ces chiffres sont inadéquats, étant basés sur le retour d'un questionnaire auquel 65 pour cent ont répondu.

Le nombre d'infirmières requises pour remplir les postes disponibles en 1948 était évalué à 8,000. Bien que la demande d'infirmières semble excéder de beaucoup l'offre, combien de gens sont au courant de l'augmentation proportionnelle du nombre d'infirmières et de la population?

Durant les 20 dernières années, le nombre d'infirmières enregistrées au Canada, en service actif, s'est augmenté de 180 pour cent et actuellement on compte 41,159 infirmières. Le nombre d'infirmières graduées a marché de pair avec l'accroissement de la population.

En 1931, il y avait 1 infirmière graduée pour 690 de population; en 1941, 1 pour 445; en 1948, 1 pour 349.

Il y a eu des changements très marqués et significatifs dans les principales catégories de la profession, tel que démontré par le tableau suivant:

Infirmières du service privé: 1930 (6,370—60%); *1943* (6,327—29%); *1948* (2,886—15%). *Infirmières dans les hôpitaux: 1930* (2,639—25%); *1943* (10,705—48%); *1948* (12,846—67%). *Infirmières en hygiène publique: 1930* (1,521—15%); *1943* (3,241—15%); *1948* (3,017—16%).

Vous remarquerez que le service privé, comptant 60 pour cent du total des infirmières, est tombé à 29 pour cent, bien que le nombre d'infirmières engagées dans ce service soit à peu près le même en 1930 et en 1943.

Dans les hôpitaux on note une augmentation considérable d'infirmières—elles passent de 2,639 en 1930 à 10,705 en 1943, soit de 25 à 48 pour cent du nombre total des infirmières. En hygiène publique, bien que le pourcentage soit le même, le nombre d'infirmières est augmenté de 1,521 en 1930 à 3,241 en 1943. En 1948, ces changements sont encore plus marqués, mais comme les renseignements que nous avons reçus sont incomplets, seulement 65 pour cent des questionnaires nous sont revenus, nous ne donnerons aucun chiffre.

Le Comité du Programme, A.I.C.

Lors de la réunion de ce comité en janvier, divers projets furent étudiés et l'on adopta que les démonstrations et les exhibits suivants seraient présentés lors du congrès biennal de Vancouver: (1) Le nursing en neurologie; (2) posture en nursing; (3) démonstration de l'équipement employé en nursing industriel; (4) les nouvelles trousses des infirmières du V.O.N.; (5) service central; (6) l'équipement d'une pouponnière de prématurés; (7) salle post-opératoire — chirurgie pulmonaire; (8) chirurgie cardiaque: soins pré- et post-opératoires; (9) programme d'éducation populaire de la division de la tuberculose; (10) l'équipe de la transfusion; (11) appareils audiométriques — appareils d'optique — le diagnostic de la teigne à l'aide de la lumière de Wood; (12) budget alimentaire en nutrition; (13) emploi du tube Cantor en obstruction intestinale; (14) l'équipe travaillant au rétablissement du malade à l'hôpital et en dehors (on appuiera sur le rôle de l'auxiliaire sociale); (15) l'équipement employé à domicile pour le traitement de l'arthrite; (16) traitement de la poliomyélite antérieure — des brûlures; (17) diagnostic et traitement du cancer; (18) faveurs et cartes d'invités, etc.; (19) nouveau genre de lits mobiles; (20) présentation de pellicules cinématographiques; (21) rein artificiel; (22) réhabilitation; (23) le nursing en pédiatrie chirurgicale; (24) le nursing en pédiatrie médicale; (25) le lit Foster; (26) la salle post-opératoire; (27) le nursing en psychiatrie — une série de photographies sera utilisée pour illustrer les soins donnés aux malades depuis l'admission au départ. Des infirmières feront des démonstrations.

Les Besoins du Malade

Les infirmières des hôpitaux d'Angleterre ont formé un sous-comité chargé d'étudier le travail des infirmières en rapport des besoins du malade. Bien qu'une étude ait été faite dans ce sens par le "Nuffield Provincial Hospitals Trust," le sous-comité est d'avis qu'une étude supplémentaire doit être faite, afin de donner une idée optime des soins requis par diverses catégories de

malades de leur admission à leur départ de l'hôpital et durant leur convalescence.

Une telle analyse serait très utile comme complément de l'enquête qui se fait actuellement.—*Extrait du* "What The Royal College of Nursing is Doing" (16 fév. 1950).

Le Rapport des Spécialistes

Dans un communiqué de presse de l'Organisation Mondiale de Santé, on rapporte les recommandations du comité pour remédier à la pénurie d'infirmières. Dans l'opinion du comité, les efforts doivent porter sur les trois points suivants: (a) Recruter des candidates pour tous les divers cours donnés; (b) intensifier une meilleure utilisation du personnel; (c) prendre les dispositions pour faciliter l'enseignement.

Le comité fait les recommandations suivantes:

1. Qu'une enquête nationale et internationale soit faite, afin de connaître les facteurs défavorables au recrutement (profession plus attrayante, coutumes, tradition, manque de préparation).

2. Comme les facteurs énumérés ci-dessus ont une influence directe sur le statut social et économique de la femme, sur l'attitude du personnel des services de santé et des membres des autres professions, il est recommandé que cette étude soit faite par un comité comprenant un psychologue et un sociologue.

3. Qu'une étude conjointe de O.M.S. et d'un autre organisme soit faite sur les conditions de travail, heures et salaires du personnel infirmier, conditions de santé, etc.; que l'on étudie les qualifications du personnel, si la surveillance est suffisante, les standards du service et les problèmes du recrutement. Que le Conseil International des Infirmières, lequel n'a aucune attache politique, soit chargé d'une enquête témoin (pilot study).

La médecine moderne, tenant compte de l'influence du physique, du social, et du mental, exige un changement fondamental de l'enseignement aux infirmières: (a) Dans les pays où les études d'infirmière sont bien organisées, une nouvelle orientation s'impose, afin que les étudiantes reconnaissent et comprennent les problèmes psychologiques; (b) dans les pays où l'établissement d'écoles d'infirmières est chose relativement nouvelle, les études devraient être dirigées dans le même sens.

Une série de recommandations, concernant les qualifications requises du personnel infirmier, a été présentée. Le rôle de ce comité de l'O.M.S. doit être: (1) De procurer aux gouvernements des renseignements sur toutes les questions concernant le nursing, comprenant les programmes d'étude de par le monde; (2) de favoriser l'éducation par des seminars internationaux sur les problèmes du nursing et favoriser partout la distribution de brochures sur le nursing.

Le comité des spécialistes recommande aussi à l'O.M.S. de faire des recherches afin de déterminer, à l'aide de méthodes anthropologiques et sociales, les besoins réels des populations.

L'Organisation Internationale du Travail

Cette organisation fit la déclaration suivante à la seconde réunion de l'O.M.S.: "Que l'O.I.T. est intéressée particulièrement dans deux aspects de la santé mondiale—en premier lieu, dans la santé des ouvriers de l'industrie et dans le développement d'un programme en hygiène industrielle; en second lieu, dans *les conditions de travail du personnel employé dans les services de santé* (hôpitaux, agences diverses, etc.). L'O.I.T. s'intéresse particulièrement aux conditions de travail des infirmières à travers le monde et portera son attention à l'amélioration de ces conditions.—*American Journal of Nursing* (déc. 1949, p. 766).

Brochure Revisée

L'Association des Infirmières du Canada vous présente avec fierté la brochure intitulée "What You Want to Know about Nursing" entièrement revisée. Il y a longtemps que cette brochure était attendu mais vous verrez que cela en valait la peine.

Il nous fait plaisir de vous informer que cette jolie brochure a été publiée en français et en anglais par le Ministère de la Santé Nationale, Division de l'Information.

Dans toutes les bibliothèques scolaires ce livre aura sa place, comme entre les mains des élèves des écoles supérieures, et nous l'offrirons avec fierté aux directeurs des maisons d'enseignements. Le format est commode, l'impression soignée, et les illustrations photographiques d'après nature sont vivantes. Le texte donne les exigences des diverses provinces et les qualifications requises des candidates.

Un message par le Dr. G. D. W. Cameron, Sous-Ministre de la Santé Nationale, donne du prestige à la brochure et touchera les

jeunes filles ayant de l'idéal. Le Ministère de la Santé National a déjà fait parvenir un exemplaire à chaque association provinciale des infirmière. Ces brochures seront distribuées par l: Ministère de la Santé de chaque provinc >.

WHEN THIS NUMBER of the *Journal* reaches you, the 1950 biennial meeting for which you have been planning for months will be just around the corner and your plans will be pretty well crystallized. Although this is being written on a gloomy day in early April, there has been already a heavy registration for both Work Conferences and General Interest Sessions. If, however, at the last moment you find yourself able to go to Vancouver, do not despair because someone else may have had to cancel a reservation. Contact National Office as quickly as possible, fill in your registration forms correctly, stating your preferences, and we will do what we can to make a place for you.

If the conferences are all bulging at the seams, there are always the General Interest Sessions. In these sessions, you will find something for everyone. This part of the program promises to be provocative, interesting, and informative. The only trouble will be that we cannot all be everywhere at once.

In earlier issues, we have mentioned three Work Conferences that should make a special appeal, namely, "Staff Education," "Meeting the Total Needs of Long-Term Patients," and "Student Nurse Work Conference." We can now present to you the outlines for these conferences:

STAFF EDUCATION

Consultants: **May Palk,** educational director, Toronto Branch, V.O.N.; **Eileen Cryderman,** director of nursing service, East York-Leaside Health Unit, Toronto; **Gladys Sharpe,** director of nursing, Toronto Western Hospital; **Helen Carpenter,** lecturer, University of Toronto School of Nursing.

Work conference purpose: To provide an opportunity for the study of certain aspects of an educational program designed to develop the optimum potentialities of each nurse and thereby result in an improved nursing service.

Overview: The development of the potentialities of each nurse through a co-operative educational process is a premise widely acknowledged. That such development results in an improved nursing service with heightened satisfaction to the participant is also accepted. In this work conference it is proposed to study and share experiences and ideas related to the foregoing assumptions. It is generally recognized that nurses employed in the various fields of nursing experience common problems. It is suggested, therefore, that registrants select an area of interest and study their problems together, thereby enriching the discussion.

Sub-topics (areas of interest):

1. THE ORIENTATION OF THE NEWLY-APPOINTED NURSE.
   Is the principle of orientation sound? If so, by whom should the program be initiated? Should it precede or parallel employment? How may the success of such a program be determined?
2. THE IN-SERVICE PROGRAM FOR STAFF NURSES.
   What measures might be taken by the employing agency to discover the specific needs of staff? How may the individual nurse be assisted to recognize

her needs? Should all organizations providing nursing service accept responsibility for the continued development of staff? Should the responsibility for educational opportunity be shared? How may the success of such a program be assessed?

3. SPECIFIC METHODS OF STAFF EDUCATION.
   How may the methods of interview, individual conference, group conference, project, committee and research be employed in the development of educational activities?

Additional or alternate aspects of the topics may be discussed as indicated by the interests and problems of the registrants.

MEETING THE TOTAL NEEDS OF LONG-TERM PATIENTS

Consultants: **Dr. Martin Cherkasky,** Home Care executive, Montefiore Hospital, New York; **Alice Gage,** supervisor, Montreal Branch, V.O.N.; **Christine Livingston,** chief superintendent of nurses, V.O.N., Ottawa; **Pearl Morrison,** superintendent, Queen Elizabeth Hospital, Toronto; **Helen Sutherland,** provincial supervisor, T.B. Social Service, B.C. Dept. of Health & Welfare; **Mrs. Edith Pringle,** inspector of hospitals, Hospital Insurance Service, B.C. Dept. of Health & Welfare.

General objective: To provide opportunity for a study of the needs of the long-term patient and how to use to the best advantage the personnel and community facilities available to meet these needs.

Work conference purposes: (1) To discuss the meaning of the phrase "long-term or chronic illness." (2) To consider the needs of the long-term patient and ways by which these may be met. (3) To consider problem of aging in relation to chronic illnesses and disabilities which accompany old age. (4) To consider community resources available to meet these needs such as care in the home, care in hospital. (5) To consider the need for an educational program in a hospital caring for the chronically ill patient. (6) To discuss the role of the doctor, nurse, physiotherapist, occupational therapist, social worker, and practical nurse as members of a team in meeting these needs.

Sub-topics (areas of interest):

1. NURSING CARE AND TECHNIQUES IN THE CARE OF THE CHRONICALLY ILL.
   What is the function of teamwork in the care of the chronically ill patient at home? What are the needs of the chronically ill patient? How can we meet them?
2. ADMINISTRATIVE ASPECTS OF A HOME CARE PROGRAM.
   What are some of the problems encountered both within and without the hospital in setting up a home care program? What factors might enter into the selection of patients for a home care program?
3. THE AFFILIATION OF STUDENT NURSES, EITHER IN AN AGENCY OFFERING HOME CARE OR IN SPECIAL HOSPITALS FOR LONG-TERM PATIENTS.
   How can we present a more accurate, more comprehensive picture of illness and health to the student in hospital? How can we develop an educational program for nurses in a chronic hospital? What kind of staff education programs do we need in chronic hospitals?
4. REHABILITATION OF THE LONG-TERM PATIENT.
   What is the difference between the handicapped and the chronically ill? How can we make rehabilitative services available to the long-term patient? What measures can we take to re-establish the emotionally unrehabilitable?

STUDENT NURSE WORK CONFERENCE

Consultants: **Margaret E. Kerr,** editor and business manager, *The Canadian Nurse,* Montreal; **Lenora Kelly,** acting superintendent of nurses, Vancouver Unit, B.C. Division of T.B. Control; **Isobel Black,** district supt., V O.N., Montreal; **Sr. M. Felicitas,** director of nurses, St. Mary's Hosp., Montreal.

General objective: To provide an opportunity for nursing students to meet informally on a national level and consider the challenges of professional responsibility.

Work conference purposes: (1) To consider the student's opportunity to inter-

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pret nursing to girls of her own age. (2) To discuss the values in student government and how to organize such a body. (3) To consider the purposes of a provincial nurses' association and how the provincial association promotes professional development. (4) To consider how the Canadian Nurses' Association functions in the interests of nurses and nursing.

Sub-topics:

1. INTERPRETATION OF COMMUNITIES' NEEDS FOR NURSES TO HIGH SCHOOL GIRLS.
   (a) The communities' needs for nurses and how to interpret nursing to high school girls.
   (b) Drawing up manual for use in nurse recruitment.

2. PURPOSES AND RESPONSIBILITY OF A STUDENT ORGANIZATION WITHIN A SCHOOL OF NURSING.
   (a) Purposes and responsibility of a student organization within a school of nursing.
   (b) Study of Constitution and By-laws now in use. (Samples on hand)
   (c) Drawing up a model Constitution and By-laws for schools of nursing having none.
3. PURPOSE AND RESPONSIBILITY OF A PROVINCIAL NURSES' ASSOCIATION.
   (a) Purpose of Provincial Nurses' Associations.
   (b) Why we need registration or licensing Acts. Study of Provincial Acts.
   (c) Relationship of Student Associations to Provincial Associations.
   (d) Relationship of Provincial Nurses' Associations to the Canadian Nurses' Association.

News Notes

ALBERTA

EDMONTON

University Hospital

Edythe Markstad, staff health service director, has been awarded 2nd prize in the annual *Canadian Hospital* essay contest. The award is a coveted one in medical circles and is made each year by *The Canadian Hos-*

pital journal to the hospital staff member contributing the most outstanding article on one phase of the operation of a medical institution. Miss Markstad's paper was entitled "Health Service for the Hospital Staff" and appeared in the hospital journal in 1949. A graduate in nursing from the University Hospital, obtaining her B.Sc. in nursing at the University of Alberta, Miss Markstad organized the hospital's health service in 1944 and has directed it ever since. With the award, she received $50.

Considered one of the finest health services operating in any Canadian hospital, the plan has served as a pattern for many other institutions. It provides periodic physical examinations, treatment benefits and inclusion under the Blue Cross plan, the hospital paying 50 per cent of the Blue Cross dues.

BRITISH COLUMBIA

Chemainus

Minnota Grinyer, a 1930 graduate of Niagara Falls General Hospital, and former superintendent of the Scott Memorial Hospital, Seaforth, Ont., is now matron of Chemainus Hospital. Miss Grinyer has taken post-graduate courses in operating-room technique and ward management in hospitals in London and Paris.

Kelowna

At a recent general business meeting of Kelowna Chapter P. Trueman was elected convener for the annual dance to be held June 22, M. Winsor and D. Kinnear acting as assistants. A Membership Committee, consisting of J. M. Gardner and D. Brannon, was elected to stimulate interest in chapter activities and to contact any new nurses that may come to Kelowna. M. Werts and M. Rolph are the new members of the Bursary Committee. M. Davies and H. Empey were chosen to represent the chapter at the C.N.A. convention in Vancouver. A decision was reached to send a per capita grant of 50 cents for each registered nurse of the chapter to the R.N.A.B.C. to help defray the entertainment expenses incurred by the provincial association at the biennial.

Mrs. Rolph, councillor for Kamloops-Okanagan District, gave a brief report of the last council meeting. S. Blackie, as official chapter delegate, commented on the R.N.A.B.C. annual meeting. Miss Davies urged all members who are not already subscribers to *The Canadian Nurse* to send in their subscriptions as soon as possible. Highlighting the meeting was a letter from Alice Wright, R.N.A.B.C. executive secretary, thanking the chapter members and the Kelowna citizens for their hospitality to the nurses attending the convention.

Sunday, May 14, was the day of the church parade at First United Church. The service was held to commemorate Florence Nightingale's birthday and was also a memorial to those Canadian nurses who gave their lives in the service of their country.

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New Westminster

A large number of friends of C. Elizabeth Clark, including many graduates of the Royal Columbian Hospital where she was superintendent of nurses from September, 1930, to September, 1949, attended a reception in her honor held at the Marpole Infirmary. Co-hostesses for the affair were Mrs. M. Law, superintendent of provincial infirmaries, and Mrs. I. Buckley, bursar.

Miss Clark has now taken up her duties at Vernon where she is matron of the Home for the Aged. Prior to coming to New Westminster in 1930, she was superintendent of the Vernon General Hospital for ten years. Since leaving the Royal Columbian Hospital she has been temporarily on the staff of Marpole Infirmary.

Prince George

The following officers are serving for the Fort George Chapter during the coming months: President, Mrs. G. Geddis; vice-president, M. McKinley; secretary, Ethel Jones; treasurer, Mrs. M. T. Green; press representative, E. Sutton. Recent projects include the purchase of a chesterfield for the nurses' home and the establishment of an annual bursary for student nurses.

At a recent meeting an interesting talk on "Psychosomatic Medicine" was given by Dr. Feurheller. Films provided by the National Film Board and the public health department have also been shown.

Vancouver

Instead of its regular May meeting, the General Hospital Alumnae Association heard a series of speakers discuss the subject of "Poliomyelitis." Plans for the alumnae banquet for the graduation class were cancelled as it was impossible to secure suitable accommodation. As a substitute a special reception was held in Brock Hall on May 8 following the rehearsal for graduation. At this time each of the new graduates was given a gift certificate for either a silver spoon or ash-tray mounted with the school crest.

MANITOBA

Forty-nine public health nurses from the provincial health units attended the three-day staff education conference held in April in Winnipeg. The program included the following: The Health Survey, Dr. M. R. Elliot; The Value of Records and Reports in T. B. Control, Dr. E. L. Ross, Misses E. J. Wilson, J. Williamson; Report of conference on V.D. Control, Dr. K. J. Backman, Miss A. Armstrong; Telebinocular machine: Description and demonstration of its use, Miss A. Laporte, St. Boniface health unit; Public Health Nursing Problems in Child Guidance, Dr. T. A. Pincock, Psychopathic Hospital, W.G.H.; Amputations, Mr. Romalis, Acme Artificial Limb Co.; Exercise for the Patient with Hemiplegia, Dr. Pincock, assisted by Miss M. Wilson, occupational therapy department, Deer Lodge Hospital, Winnipeg; Physical Fitness, Mr. H. Devenney; Summer

at Minnesota University, Misses J. DeBrincat, L. Johnson, M. Wilson. A visit was also arranged to the maternity pavilion, Winnipeg General Hospital.

Brandon

Mrs. E. Griffin was in the chair at a recent meeting of the Association of Graduate Nurses held at the General Hospital. It was reported that, because of continued contributions to the Scholarship Fund, an amendment has been made to the effect that, if a suitable applicant can be obtained each year, an award should be made annually, rather than every second year. A nominating committee, composed of Mrs. F. Durnin, convener, Mrs. I. Buchanan, and M. Hettle, was chosen. Mmes Griffin and R. Kent were delegates to the M.A.R.N. annual meeting in Winnipeg.

J. Markey's group took charge of the program and the members were shown two Red Cross films—"Miracle Fluid" and "Great Also in Peace." These films portrayed the work done by volunteers and how 24-hour duty was performed. Another feature of interest was the method of taking blood from donors. The film also showed how it was prepared for refrigeration and sent on mercy calls for babies and others by plane to the far north.

The Masonic Temple was the scene of an enjoyable social evening held by the married nurses' section of the association. Whist was played and the winner of the draw prize was

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* Public Health Nursing.

* Administration and Supervision in Public Health Nursing.

Supervision in Psychiatric Nursing.

Supervision in Obstetrical Nursing.

Supervision in Paediatric Nursing.

Mrs. J. G. Greaves. Lunch was served and the evening concluded with old-time dancing. Arrangements were handled by Mrs. M. W. Long.

WINNIPEG

The month of March marked the official opening of the Princess Elizabeth Hospital for the chronically ill, situated on the same site as the King George and King Edward hospitals. This hospital of 208 beds has been constructed for the complete care, comfort, and safety of the patient.

General Hospital

The annual alumnae dance and bridge was held in April. Other items of interest include: Ethel Gilroy, the first alumnae president, was made an honorary member of the association. Last year the alumnae was invited to present a report for the Winnipeg General Hospital Annual Report. Twice each year the alumnae president gives a one-hour talk to the senior class at the hospital on the alumnae association and its chapters. Two scholarship awards were made for post-graduate studies. The hospital staff sitting-room was refurnished by the alumnae with the Jubilee Fund.

NEW BRUNSWICK

EDMUNDSTON

A dinner at Madawaska Inn was enjoyed prior to a recent business meeting of Edmundston Chapter, with the president, Mrs. A. Titus, in the chair. The chapter had as guests members of the Hotel Dieu Alumnae Association and two guest speakers from the neighboring town of Madawaska, Me.

Ellen Demers, public health nurse for Madawaska, told of the work being done in the State of Maine by public health nurses. She gave a brief history of this branch of nursing, describing the various territories covered and the regular clinics held in each district. Elva Plourde, plant nurse for the Fraser paper mill in Madawaska, spoke on "Industrial Nursing" and stressed the importance of the nurse in industry. She reviewed the development of this phase of nursing, outlining the duties of a plant nurse and the co-operation required between employee, nurse, and management.

Mrs. Titus extended the members' thanks to the speakers. Four new members were welcomed into the chapter—J. St. Germain, R. Martin, B. Levesque, and Mrs. A. Michaud.

SAINT JOHN

The Nurses' National Memorial Services were held on May 7 at Centenary-Queen Square Church and at the Cathedral of Immaculate Conception.

St. Joseph's Hospital was the scene of a recent meeting of Saint John Chapter when 55 members attended. B. Selfridge, the president, was in the chair. The treasurer's and registrar's reports were read and adopted. Misses Wetmore, Henderson, and McAllister

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will serve on the N.B.A.R.N. Nominating Committee for the 1950-52 biennium. After business was concluded, Dr. Petrie, whose hobby is colored photography, showed films of many places he had visited across Canada. Miss McAllister thanked the speaker and Miss Selfridge voiced the members' appreciation.

The Private Duty Section of the local chapter recently sponsored a delightfully arranged bridge and dance at the Admiral Beatty Hotel. The event was held under the patronage of His Honor the Lieut. Governor and Mrs. MacLaren, His Worship the Mayor and Mrs. E. W. Patterson, Dr. and Mrs. J. K. Sullivan, and Mr. and Mrs. R. H. Gale. The patrons were received by M. Downing, B. Selfridge, J. Crammond, and M. Petersen. Bridge was enjoyed at some 50 tables. About 300 guests attended. The conveners for the dance were J. Crammond and A. Peterson, assisted by K. Lawson and Miss McDonald. Mrs. G. Trites was in charge of the bridge, assisted by Mmes F. Cobham and L. Rooney. The object of this affair was to raise money for the Saint John Chapter registry.

A large number of used uniforms were collected from private duty nurses and sent to the C.S.C.F. National Clothing Depot, under the convenership of K. Lawson. (See Oct. 49 *Journal*, p. 760.) A letter of appreciation was received.

General Hospital

B. Selfridge was in the chair at a recent meeting of the alumnae association when 46 nurses were present. Alice Carney is convener for the dinner and dance to be held in honor of the 1950 graduates. There are 50 members in this class. The 62nd anniversary of the training school is being observed at this time. The graduates from S.J.G.H. now number 1,072. On this occasion a letter of greeting will be sent to each member. A history of the training school will be published in the near future. Preliminary plans were made for a rummage sale to be held in the fall under the convenership of Miss Selfridge.

The guest speaker was Mrs. A. W. Estey who gave a vivid and humorous account of her trip abroad. Members brought to the meeting articles of food which were packed for shipment to nurses overseas.

Janice Moore and Marjorie Horsnell, both of Fredericton, and recent S.J.G.H. graduates, have joined the R.C.A.M.C. as nursing

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sisters and will train in Toronto and Camp Borden. They have been on the staff of Victoria Public Hospital and a number of social gatherings were held in their honor prior to their departure.

Lancaster (D.V.A.) Hospital

The annual meeting of the Lancaster Nurses' Association was held recently with H. McCallum, retiring president, in the chair. The following officers were elected: President, E. Price; vice-president, A. Shannon; secretary, E. Abbott; treasurer, K. English; visiting convener, G. McMillan.

Another enjoyable event was the bridge held by the executive for the association members.

St. Stephen

Mrs. L. W. Brownrigg's home was the scene of a recent meeting of St. Stephen Chapter when the guest speaker was Dr. C. R. Trask, medical health officer for Charlotte and Saint John Counties. His subject was "Mass Audiometry in the Saint John Schools." Dr. Trask noted the early method of diagnosis and treatment used in impaired hearing and stated that, due to the many advances in drug therapy, today there are fewer cases of mastoiditis, otitis media, and other infections. He revealed that, in 1926, the Bell Telephone Laboratories, in cooperation with the American Federation of Organizations of the Hard of Hearing, developed a test for hearing loss that became widely used and is known today as the Western Electric 4C Audiometer. This equipment is used for group screening and has many merits, including the simplicity of the standard equipment which offers no technical problems for its administration.

Early in 1948, the Kinsmen Club of Saint John offered to assist the local board of health in any new project and, after careful consideration, it decided to embark on a program of prevention of deafness in school children. Up to March 31, 1950, 5,326 students had been tested. The club will help any child in Saint John who requires financial aid in the treatment of a hearing defect.

At the close of Dr. Trask's talk, each nurse present was tested for impaired hearing.

Marion Gage, a Montreal General Hospital graduate, is now on the Chipman Memorial Hospital staff.

ONTARIO

District 4

Hamilton General Hospital

The Spring meeting of the alumnae association was held at Mt. Hamilton Hospital with Elizabeth Ferguson presiding. At the conclusion of business, Miss Welstead, the social convener, introduced Dr. William Deadman, Hamilton's Citizen of the Year, who gave an interesting talk on "Public Relations." A social hour followed.

St. Catharines

The following officers will serve on the executive of the Mack Training School Alumnae Association: Honorary president, E. Bell Rogers; president, Mrs. Jean Forsythe; vice-president, Isla Misener; secretary, Eileen Brough; treasurer, Norma Rolls; *Canadian Nurse* representative, Stella Murray.

At a regular alumnae meeting Dr. O. Younghusband spoke on "Heart Surgery."

Welland

A meeting of Niagara Chapter was held at the General Hospital when the guest speaker was Mrs. Frank House who told the members something of her work with UNRRA in China.

District 5

Toronto Western Hospital

At the December meeting of the alumnae association, held in the Edith Cavell Residence, a beautiful grandfather clock, with Westminster chimes, was presented to the residence in honor of T.W.H. nurses who served in World War II. The presentation was made by Mrs. J. Miller, alumnae president, and Gladys Sharpe, director of nurses, received the gift.

The nurses' residence was the scene of a Coffee Party in honor of the graduation class. Guests were received by G. Sharpe, B. McPhedran, M. Agnew, and Mrs. Miller. The nurses and their escorts later attended a dance at the Royal York Hotel held for the new graduates by the alumnae.

A Daffodil Tea held in April by the alumnae featured a sale of home-baking and many lucky draws made by the first graduate of the hospital—Mrs. I. P. MacConnell. M. Steed was the social convener for this event.

District 7

Brockville

A very interesting refresher course was sponsored by the chapter when the following lectures were given: Obstetrics in Britain, Professor J. Chassar Mair, Kingston; Newer Trends in the Practice of Medicine, Dr. John Plunkett, Ottawa; Modern Trends in Psychiatry, Dr. H. C. MacCuaig, Kingston; The Care and Management of the Premature Infant, Dr. Fred W. Jeffrey, Ottawa, and Dr. Roy MacGregor, Kingston; Where Nurse and Social Worker Meet, Mr. Ernest Majury, Toronto.

At a recent regular meeting seven new members were received. Florence Walker, secretary-treasurer, R.N.A.O., was guest speaker and her topic was "The R.N.A.O.—Your Professional Organization."

QUEBEC

Montreal

Herbert Reddy Memorial Hospital

Mrs. Rutherford presided at a regular meeting of the alumnae association. Following business, a demonstration on make-up was

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Superintendent of Nurses,
Mountain Sanatorium,
Hamilton, Ontario.

given by Mrs. J. Rockliffe and Mrs. J. Daigle of the Beauty Counselors of Canada, Limited, to which all graduates were invited.

Mrs. H. Croke has transferred from O.P.D. and is now assistant night supervisor. G. Brochu, having completed a post-graduate course at St. Michael's Hospital, Toronto, is in the O.R.

McGill School for Graduate Nurses

Students at the school are shown in the accompanying photo during a visit to the medical department of Northern Electric Co. Ltd. in Montreal. More than 20 were included in the party which, in addition to visiting the medical department, participated in a short tour of the shops and offices. Shown with the visitors is Dr. M. G. Townsend, medical director of the company, who is outlining the use of the "Ortho-rater," a vision testing unit recently installed in the department.

Royal Victoria Hospital

The alumnae association recently held their annual dinner in honor of the 1950 graduation class when Mrs. F. A. C. Scrimger, the president, was in the chair. F. Munroe, former superintendent of nurses, gave the toast to the graduates, to which Margot Ross responded. Dr. D. Sclater Lewis, F.R.C.P. president of the Royal College of Physicians and Surgeons of Canada, addressed the gathering, which consisted of 103 graduates and 130 alumnae members. His subject was entitled "As We Were . . .", being a picture of the early days at R.V.H. Helene Lamont, present superintendent of nurses, announced the prize winners as follows: Mabel F. Hersey prize, D. Watson; Nellie Goodhue prize, J. Pritchett; Alexina Dussault prize, M. Clark. Medical staff prizes—1st division, M. Ross; 2nd division, S. Boivin; Dr. Tremble's prize for bedside nursing, G. Nicholl.

A lectern and lights, in memory of Grace Martin, former assistant superintendent of nurses, were recently dedicated by the Rt. Rev. John Dixon, Lord Bishop of Montreal, in a brief ceremony in the chapel of the

hospital. Many doctors, nurses, and former friends of Miss Martin attended.

Beryl MacRae was a visitor at the hospital from Fort George, Que. M. V. Peever writes from Island Lake, Man.: "Miss Goodman and I are enjoying our work with the Indian Health Services very much. We find it much more to our liking than hospital duty. However, we admit that at times we miss the old school and the wonderful people we met there."

QUEBEC CITY

The following officers were elected at the annual meeting of the English Chapter, District 9, A.N.P.Q.: Chairman, Mrs. J. Green; vice-chairmen, Misses Fischer, Dawson; secretary-treasurer, Mrs. L. Kennedy; assistant secretary, A. MacDonald; hospital and school of nursing section, E. Felsing; general nursing section, M. Jack, Mrs. J. Cormack.

Jeffery Hale's Hospital

Miss Bancroft has resigned as general duty nurse to accept a position at Bay Comeau, Que., and Miss Gray is at Grand'Mère, Que.

SASKATCHEWAN

The Saskatchewan government has again announced the award of ten bursaries to enable nurses to take post-graduate courses in teaching, supervision, or administration. A committee of nurses has been appointed to consider applications and to make recommendations regarding their award.

MOOSE JAW

General Hospital

The official opening of the new addition to the hospital was attended by the Hon. Mr. Bentley, Minister of Health, and Dr. Mott, Acting Deputy Minister of Health, and Mayor L. H. Lewry representing the city. A reception was held for the public the following day.

New staff members include: G. Barnes, supervisor of the new pediatric department; Mmes W. Houston, Thomson, T. Johnstone, J. Willis, and Barkhoff, who are doing general duty. Resignations include: B. Fordyce, I. McGee, J. Davey, and D. Mackie, the latter to be married.

The student body is sending Miss Heisler as their representative at the C.N.A. convention in Vancouver.

Providence Hospital

Bernice Gillis has joined the dressing room staff and Eileen Thoreson is a new addition to the teaching staff, replacing Marion Procter who resigned to be married. Cecilia Duddy, Dorothy Hamerness, and Doris Appleton have left the staff to go to the Pacific Coast.

SASKATOON

City Hospital

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were guests of the School of Nursing students at the nurses' residence. The occasion was a function called "Prelude to Nursing" and consisted of instructive exhibits and displays of nurses' activities on and off duty. Lucy Willis, educational and social director, advised and instructed the students of the school in their project. The response from the high school students was very gratifying.

St. Paul's Hospital

The new wing of the hospital, containing all the latest appliances, was unofficially opened in March by His Excellency Bishop Pocock and the formal opening took place in May on National Hospital Day. The new wing has a 40-bed capacity, bringing the hospital total to 320.

During Easter week the "Freshmen B" class entertained Sisters, instructors, and fellow students at a delightful concert and the Sodality held a successful Spring Tea and Novelty Sale.

M. Brochu of B.C. called at the residence recently to renew acquaintances.

Saskatoon Sanatorium

New staff members include: Betty Galvin, Florence (Wanner) Person, Ruby Glencross, Phila Benning, and Lois (Olson) Wanner. Mary Waber has left on an extended motor trip through Eastern Canada and the U.S.

YORKTON

In March the Yorkton Chapter held its annual banquet with Dr. S. Potoske as guest speaker.

The Major Livingstone Chapter, I.O.D.E., has undertaken the teaching of handicraft to convalescent patients at the General Hospital. Ten students of the 1953 class recently received their caps at a capping ceremony held in the nurses' residence.

Book Reviews

The Horner Manual—Aids to Diagnosis. 80 pages plus index. Published by Frank W. Horner Ltd., 950 St. Urbain St., Montreal 1.

"Aids to Diagnosis," while planned primarily to be a source of reference for the medical practitioner and student, contains many sections that would be useful for nurses also. This little manual covers a range of subjects, including blood chemistry, the Rh factor, the meaning of various tests such as gastric analysis, fluid examination, etc. One of the most useful sections is the table of treatments and antidotes for various poisons.

Any nurse may receive a copy of the Horner Manual *free of charge* by writing to the firm at the above address.

Public Health in the World Today, edited by James S. Simmons. 332 pages. Published in Canada by S. J. Reginald Saunders & Co. Ltd., 84 Wellington St. W., Toronto 1. 1949. Price $6.25.

Reviewed by Ruth M. Morrison, Assistant Professor, Department of Nursing & Health, University of British Columbia.

I approached this book with excitement partly caused by the sweep of the title, partly by the roster of names of contributors, and partly by the unusual dedication:

"To a new concept of service through public health, and to a new vision of the world of the future" in relation to human dignity, opportunity for the family to provide for itself in peaceful surroundings in a "world wise enough to limit his propagation to the potential fertility of the earth."

The book was edited and published as a result of the efforts of the Harvard School of Public Health to enrich its curriculum through distinguished guest speakers. I was disappointed to find that, while experts in their fields dealt accurately and vividly with such subjects as industrial health, the army health program, the child in world health and social welfare, statistics and sanitation, no contribution appears from a nurse. One wonders why such people as Ruth Freeman, Lucile Petry, Pearl McIver and others, who live and work on the Eastern Seaboard, were not drawn upon by the Harvard School of Public Health to interpret to the Harvard students the purpose and function of the largest (numerically) member of the public health team.

Dean Simmons, by the skilful use of a story about smallpox, points out the lag which occurs between knowledge and its application. Other experts discuss the field in which they are particularly versed. While I found each interesting and valid I was disappointed that the comprehensiveness of the title was misleading in that most of the historical, statistical, and other data was based in the U.S.A. rather than in the world. The fault, if fault there is, lies not with the contributors but with the choice of name.

This book will be valuable to public health nursing students as reference material, to the staff nurse as a reading source of concise information, and to other readers for its general interest in the health field. Because of its price it is likely to be more frequently found in schools rather than in private libraries.

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Clinical Instructor for Surgical Nursing, preferably with experience, by Sept. 1. 500-bed hospital. Salary: $195-225 (bonus for degree). Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

Operating-Room Nurse & General Duty Nurses for 90-bed hospital in B.C.'s Cariboo District. Salary: $185 for General Duty—$195 for O.R. less $40 maintenance in comfortable nurses' home. Yearly increase of $7.50. Fare refunded after 6 mos. service. 44-hr. wk. 28 days holiday after 1 yr. service. Proportionate holidays after 6 mos. All statutory holidays. Progressive town offers wide variety of winter & summer sports. Twice daily plane service to Vancouver. For further information apply Miss G. Gowans, Director of Nursing, Prince George & District Hospital, Prince George, B.C.

Operating-Room Nurse & Graduate Nurse for General Floor Duty for 30-bed General Hospital. Apply, stating qualifications, Supt., Groves Memorial Hospital, Fergus, Ont.

Public Health Nurse for generalized service in urban municipality. Salary: $1,800-2,300 according to experience. Apply, in writing, stating qualifications, experience, age, etc., Medical Officer of Health, Dept. of Health, Kingston, Ont.

Registered Nurse for charge of Central Supply Room. 140-bed hospital. Also **General Duty Nurses for Operating-Room & Wards.** 48-hr. wk. 3 wks. vacation. Blue Cross plan. Apply Acting Director of Nurses, Women's College Hospital, Toronto 5, Ont.

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Staff Nurses for beautiful new 125-bed Private General Hospital in city of 40,000. 5-day, 40-hr. wk. $200 base pay, scheduled increases. Apply Director of Nurses, Yakima Valley Memorial Hospital, Yakima, Washington.

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Nursing Arts Instructor, Educational Director, Clinical Instructor immediately. The hospital, located in capital city, is connected with large clinic & college which aids greatly in teaching students. Apply Director of Nurses, Bismarck Hospital, 6th & Thayer, Bismarck, North Dakota.

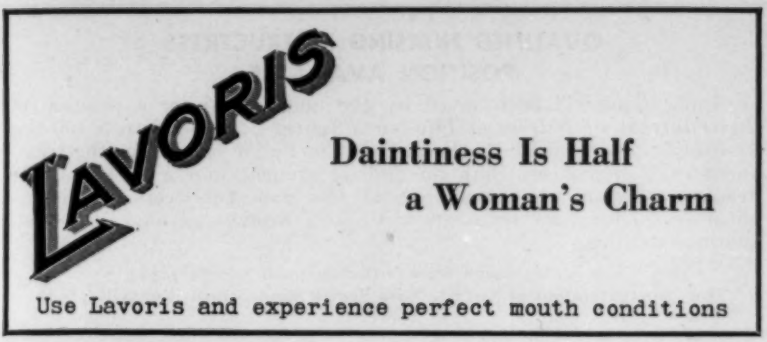
Clinical Teaching Supervisor & Science Instructor for 125-bed Pediatric Hospital. 8-hr. day, 6-day wk. 1 mo. vacation annually. Apply, stating qualifications & salary expected, Supt. of Nurses, Children's Hospital, Winnipeg, Man.

Supervisors for General Wards & Graduate Nurses for General Duty for 188-bed hospital. Salary: $185 & $160 respectively with maintenance. 44-hr. wk. For full particulars apply Supt. of Nurses, General Hospital, Medicine Hat, Alta.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

Staff Nurses, eligible for registration in Michigan, for all services in modern 200-bed hospital. Salary: $216 per mo. for 44-hr. wk. 6 mos. increase. $10 extra for 3-11 & 11-7 duty. 7 paid holidays. 2 wks. vacation & 12 days sick leave per yr. Cafeteria meal service. Laundry furnished. Apply Director of Nurses, General Hospital, Pontiac 18, Michigan.

Graduate Nurses for General Duty in fully modern 82-bed hospital. Salary: $145 per mo. ($150 after 6 mos. service) plus full maintenance in separate, modern residence. 8-hr. day, 6-day wk. 30 days holiday with pay after 1 yr. service. 14 days sick leave with pay in any 1 yr. & all statutory holidays. Apply Supt., Union Hospital, Canora, Sask.



Graduate Dietitian at Ontario Hospitals in Kingston, Whitby, Woodstock. Initial salary: $2,140 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. at above hospitals.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, St. Thomas, Toronto, Whitby, Woodstock. Initial salary: $1,840 per annum plus $180 Cost of Living Bonus, less perquisites ($26.50 for room, board, laundry). Annual increment, accumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 6-day wk. Apply Supt. of Nurses at above hospitals.

Registered Nurses for General Duty required for University of Alberta Hospital, Edmonton. (640 beds). Gross salary: $170 per mo. 1st year, $180 2nd year and $190 3rd year of service in hospital. $25 per mo. deducted for meals and laundry. Statutory holidays. Sick leave: 3 weeks after 1 yr. service, with annual increase of 1 wk. to a maximum of 13 wks. Blue Cross coverage on a 50% employee contributory basis. 1st class railway fare to Edmonton refunded after 1 year continuous service. Pleasant university environment. Apply Supt. of Nursing Services.

Graduate Nurses for completely modern West Coast hospital. Commencing salary: $185 per mo. less $40 for board, residence, laundry. Special bonus of $10 per mo. for night duty. $10 annual increment. 44-hr. wk. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. accumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Registered Nurses for General Duty in 45-bed hospital. Salary: $120 plus full maintenance. 8-hr. duty, 6-day wk. 3 wks. holiday after 1 yr. service plus statutory holidays. Apply Supt., Bruce County General Hospital, Walkerton, Ont.

Registered Nurses for General Duty for modern 200-bed hospital in Niagara Peninsula. Salary: Days, $140; evenings, $150; nights, $145—plus maintenance. Straight 8-hr. duty. Comfortable nurses' residence. Transportation refunded after 1 yr. service. Apply Director of Nursing, County General Hospital, Welland, Ont.

Registered Nurses for General Staff Duty on Rotation Service. Apply, Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

Graduate Nurses for General Duty at R.W. Large Memorial Hospital of the United Church of Canada, located at Bella Bella on the B.C. coast, 300 miles north of Vancouver. Salary: $150 gross less $25 per mo. for maintenance & laundry. Fare to hospital refunded after 1 yr. service. Vacancies July 1 & Sept. 1. Apply to Matron.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $115 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end ea. mo. 1 mo. annual vacation. 14 days sick leave. Apply Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

General Duty Nurses for modern, well-equipped hospital in picturesque Lakehead. 48-hr. wk. Cumulative sick leave. 1 mo. vacation after 1 yr. service. Gross salary per mo.: $170 less $20 for meals & laundry. $45 deducted if living in residence. Annual increment. Railway fare up to $50 with 1 yr. contract. Apply Director of Nursing, General Hospital, Port Arthur, Ont.

QUALIFIED NURSING INSTRUCTRESS POSITION AVAILABLE

Applications will be received by the undersigned for a position of ***Instructress of Nurses*** at **The Nova Scotia Sanatorium,** a 400-bed institution, operated by the Department of Public Health for the treatment of Tuberculosis. Both an affiliate student and a post-graduate teaching program have been underway for some two years. Applicants must be qualified for registration in Nova Scotia and have had post-graduate training.

Those interested may obtain further information by writing to:

The Superintendent of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

Maternity Nurses—post-graduate training preferred, not required. 48-hr. wk.; straight shift. New Maternity Pavilion opening in near future. Information concerning salaries, sick time, etc., provided after application has been received, giving qualifications, years of experience, etc. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

General Duty Nurses. 8-hr. broken day. 48-hr. wk. Gross salary: $163.40 monthly. All salaries have scheduled rate of increase. Cumulative sick leave. Pension plan in force. Blue Cross plan. 3 wks. holiday after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital for Tuberculosis, Gravenhurst, Ont.

Graduate Nurses for 40-bed hospital. Straight 8-hr. shift. Salary: $150 per mo. including bonus of $10 per mo. payable every 6 mos. Full maintenance. Apply Matron, Municipal Hospital, Vermilion, Alta.

General Duty Nurses for 400-bed hospital. New Wing just opening. 8-hr. day, 44-hr. wk. 10 statutory holidays. B.C. registration required. Salary: $175 basic. Credit for past experience. Annual increments. Vacation: 28 days after 1 yr. Sick leave: 1½ days per mo. cumulative. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Graduate Nurses for General Floor Duty. Salary: $115 per mo. Full maintenance & laundry. $60 yearly increase up to 3 yrs. Apply, stating qualifications, Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, Que.

Vancouver General Hospital requires **General Staff Nurses.** Salary: $177 per mo. increasing to $207. **Clinical Instructor** — for Surgical Nursing, preferably with experience in General Surgery & Urological Nursing. Salary: $207-232. **Instructor** — preferably with degree as chief subject will be Bacteriology. **Instructor** — preferably with previous experience in teaching & with ward experience. Duties include lectures & demonstrations in nursing arts & allied subjects. Salary: $197-222. Perquisites include: 44-hr. wk. (week-ends free); statutory holidays — 11; vacation — 28 days; sick leave — 1½ days per mo. cumulative; pension plan (if under age 35). Apply Director of Nursing, General Hospital, Vancouver, B.C.

Public Health Nurses for Generalized Program. Minimum salary: $1,900 but suitable adjustments made for experience. Car allowance of 8c per mile paid & loans made if necessary for purchase of car. Apply Supervisor of Nurses, Kent County Health Unit, Harrison Hall, Chatham, Ont.

District Nurses for Province of Alberta. Rural service. Emergency treatment, preventive & maternity program. Furnished cottage, fuel, water supplied. Salary schedule: $1,920-2,400. Sick leave, annual vacation, pension. Present Cost of Living Bonus — $21 per mo. Apply A/Director, Nursing Division, Dept. of Public Health, Edmonton, Alta.

Public Health Nurse immediately for excellent district adjacent to Calgary. Qualifications, duties & salaries as prescribed by Alberta Department of Health but University Degree in Nursing essential. Car supplied. Best modern living quarters. Apply by wire or air mail to H. C. Willson, Sec., Wheatland School Division, Strathmore, Alta.

Graduate Nurse for 10-bed hospital. Salary: $150 per mo. plus full maintenance. 1 mo. holiday with pay after 1 yr. Modern nurses' residence apart from hospital. Duties to commence as soon as possible. Apply Matron, Frontier Hospital, Frontier, Sask.

General Duty Nurses (2) for 20-bed Isolation Hospital. Salary: $180 per mo.; meals & laundry. 8-hr. duty broken. 5½-day wk. Apply Matron, Isolation Hospital, Balsam St., Port Arthur, Ont.

CANADIAN RED CROSS SOCIETY

invites applications for ***Administrative*** and ***Staff*** positions in **Hospital, Public Health Nursing Services,** and **Blood Transfusion Service** for various parts of Canada.

THE GREATEST NEED FOR OUTPOST NURSES IS IN THE PROVINCE OF NEW BRUNSWICK — BOTH AT MATRON AND STAFF LEVEL.

- Commensurate salaries for experience and qualifications. Transportation arrangements under certain circumstances.

For further particulars apply:

National Director, Nursing Services, Canadian Red Cross Society, 95 Wellesley St., Toronto 5, Ontario.

Public Health Nurses for Staff positions. Voluntary agency specializing in Tuberculosis Clinic & Home Visiting Services. Apply Supervisor, Public Health Dept., Royal Edward Laurentian Hospital, 3674 St. Urbain St., Montreal 18, Que.

Supt. of Nurses for 60-bed General Hospital. Salary: $200 per mo. plus full maintenance. Apply W. G. Martin, Chairman, Lady Minto Hospital, Cochrane, Ont.

General Duty Nurses for 60-bed hospital. Salary: $140 per mo. plus full maintenance to Registered Nurses; others in accordance with qualifications. Apply Supt. of Nurses, Lady Minto Hospital, Cochrane, Ont.

General Duty Nurses & Supervisors (2) for 100-bed hospital. Salary: $100 & $115-125 respectively. Full maintenance. Good living conditions. 48-hr. wk. 8 holidays. 3 & 4 wks. holiday annually. Apply, giving full information, Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

Instructor of Nurses. New hospital to be started this Summer. List qualifications & experience in 1st letter. Apply Supt., Chipman Memorial Hospital, St. Stephen, N.B.

Graduates with Operating-Room experience for duty in modern, well-equipped Operating-Room Dept. Gross salary: $38-44 per wk. Opportunities for advancement to Staff positions for qualified graduates. Apply C. E. Brewster, Supt. of Nurses, General Hospital, Hamilton, Ont.

Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross salary: $38-44 per wk. 88-hr. fortnight. Hospitalization & medical benefits if ill. Apply C. E. Brewster, Supt. of Nurses.

Asst. Supt. Also **Night Supervisor** for small hospital near Toronto. Apply, stating age, experience, school & date of graduation, c/o Box 3, The Canadian Nurse, Ste. 522, 1538 Sherbrooke St. W., Montreal 25, Que.

Operating-Room Nurse for 60-bed hospital. New equipment. 8-hr. day, 6-day wk. Attractive residence. Apply Supt., General Hospital, Strathroy, Ont.

Public Health Nurses for Stormont, Dundas & Glengarry Health Unit. Generalized program. Salary: $1,900 minimum with annual increments according to experience; liberal car allowance, good personnel policies. Apply Miss R. Kavanagh, Supervisor, Public Health Nursing, 104-2nd St. W., Cornwall, Ont.

Registered Nurse for General Duty. Salary: $120 per mo. plus full maintenance. Apply Supt., Louise Marshall Hospital, Mount Forest, Ont.

General Duty Nurses for modern, well-equipped hospital of 110 beds. Salary: $120 plus maintenance. Increase at end of 6 mos. & annually thereafter for 2 yrs. Accumulative sick time —medical & hospital plans available. 30 days holiday after 1 yr. service. 8-hr. day, 6-day wk. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

Operating-Room Nurse. $190 per mo. less $35 room & board. **General Duty Nurses** (2). $175 per mo., B.C. registration; $170 other. 32-bed well-equipped hospital beautifully situated on the sea, 50 miles from Victoria. 8-hr. day, 6-day wk. with long week-end following night shift. 28 days holiday after 1 yr. service plus statutory holidays. Apply Director of Nurses, General Hospital, Chemainus, V.I., B.C.

Public Health Nurse for Wentworth County School Health Service, duties to commence about Sept. 1. 1 mo. vacation; liberal car allowance provided & financial assistance available for purchase of car. Applications, stating qualifications, experience & salary expected, will be received up to *June 26* by A. F. Stewart, Wentworth County Clerk, Court House, Hamilton, Ont.

Official Directory

Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

Pres., Miss Jean Clark, c/o Dept. of Health, Edmonton; Vice-Pres., Misses F. J. Ferguson, H. Penhale; *Councillor*, Rev. Sr. Annunciata, Mineral Springs Hosp., Banff; *Committee Chairmen: Institutional Nursing*, Miss F. McQuarrie, School of Nursing, Univ. Hospital, Edmonton; *Private Duty*, Miss J. G. Brown, 202 Anderson Apts., Calgary; *Public Health*, Miss K. Deane-Freeman, 216-17th Ave. W., Calgary; **Registrar, Mrs. Clara Van Dusen, Reynolds Bldg., 10026-102nd St., Edmonton.**

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QUEBEC

The Association of Nurses of the Province of Quebec

The Association of Nurses of the Province of Quebec, created by Licensing Act, April 17, 1946, replacing The Registered Nurses Association of the Province of Quebec, Incorporated February 14, 1920.

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